

Development of Models and Standards For Bilingual/Bicultural Health Care Services for Asian and Pacific Islander Americans

*Tibetan • Urdu • Khmer
Trukese • Yapese • Fijian
Nepali • Tahitian • Tongan
Ilocano • Japanese • Bengali
Hawaiian • Korean • Tamil
Mandarin • Ponapean
Visayan • Bahasa Indonesian
Cantonese • Kosraean • Lao
Samoan • Hindi • Gujarati
Vietnamese • Punjabi • Thai
Belauan • Tagalog • Chamorro*



**DEVELOPMENT OF MODELS AND STANDARDS
FOR BILINGUAL/BICULTURAL HEALTH CARE SERVICES
FOR ASIAN AND PACIFIC ISLANDER AMERICANS:**

The Language Access Project

Revised Edition

**ASSOCIATION OF ASIAN PACIFIC
COMMUNITY HEALTH ORGANIZATIONS
(AAPCHO)**

August 1996

This paper was supported under contract No. 282-92-0065
with the Office of Minority Health, Public Health Service, U.S. Department of Health and Human Services
and does not necessarily reflect the views and opinions of the Department or its components.

Development of Models and Standards for Bilingual/Bicultural Services for Asian and Pacific Islander Americans

Table of Contents

Project Staff	i
Participating Health Centers/Project Liaisons	ii
Acknowledgements	iii
Preface to Revised Edition	iv
List of Abbreviations	v
Executive Summary	vi
 I. Background	
Barriers to Access: Definition of Problem	2
Literature Review	3
Overview of AAPCHO and Its Health Centers	4
Legislative Background	5
References	6
 II. AAPCHO Centers' Users and Operations	
Purpose of Study and Methodology	7
Findings on AAPCHO Centers' Users	8
Findings on AAPCHO Centers' Operations	11
Methods of Ensuring Language Access	13
Health Education Materials and Interventions	16
Cultural Competence	17
Staff Composition and Required Skills	18
Recruitment	19
Training	22
Other Related Health Center Services	22
 III. Financial Issues Related to Language Access	27
 IV. Impact of Managed Care Environment on Language Access	31
 V. Models, Standards, Guidelines, and Recommendations	
Evolution of Models to Ensure Language Access	35
Principles	36
Minimum Standards	36
Guidelines	37
Policy Recommendations	38
 Appendices	
A. 1990 U.S. Census Categories for APIs	43
B. Description of AAPCHO Centers	45
C. Time Study of Cost Estimates for Interpreters	51

LANGUAGE ACCESS PROJECT STAFF

Laurin Mayeno, Executive Director
Emil A. De Guzman, Program Director
Chantal Raymer, Program Assistant

CONSULTANTS

Edwin K. Eng, Study Design
Evelyn Lee, Study Design
Margaret Kim, Data Analysis
Rene Ciria-Cruz, Editing

OFFICE OF MINORITY HEALTH

Betty Lee Hawks, Project Officer
Rizalina C. Galicinao, Alternate Project Officer

Participating Health Centers/Project Liaison

Kathy Lim Kō
Associate Director
Asian Health Services
Oakland, California

Nerissa Mojica
Primary Care Health Care Coordinator
Hea Kyung Park
Project Assistant
Asian Pacific Health Care Venture
Los Angeles, California

Virginia Tong
Assistant Executive Director
Chinatown Health Clinic
New York, New York

Sharyne Shiu-Thornton
Cross Cultural Mental Health Specialist
International District Community Health Center
Seattle, Washington

Merina Sapolu
Health Educator
Kokua Kalihi Valley Community Health Center
Honolulu, Hawaii

Rosemary Dady
Director of Program Development
Northeast Medical Services
San Francisco, California

Vincent Lee
Administrator
South Cove Community Health Center
Boston, Massachusetts

Acknowledgements

The project staff would like to express appreciation to the staff, board, and patients of the participating health centers for sharing their expertise and providing information and input. We also would like to thank Betty Lee Hawks and Rizalina C. Galicinao, OMH Project Officers, for their support, endurance, and guidance.

Several organizations and individuals provided us with valuable resources and information. We especially would like to thank Dr. Robert Putsch from Pacific Medical Center in Seattle and Monica Perz of the Association of State and Territorial Health Officers for going out of their way to provide assistance.

Finally, we would like to thank the following staff members who were instrumental in the success of this project and the development of the final report: Aromie Noe, Ying-Ying Meng, Liane Dong, Nobuko Mizoguchi, Amee Manges, and Renjie Yuan.

Preface to Revised Edition

The original edition was completed by AAPCHO staff in May 1995. While the revised edition involved reorganization and changes of the first edition, effort was made to retain the original content of the report. For this reason, although the original study was conducted in 1993, some of the data from the AAPCHO health centers were not updated for the revised edition. Nevertheless, a brief new section on the impact of managed care on language access was written to provide additional points for discussion.

The following people contributed to the revised edition:

Editing:

Rod Lew
Jennifer Lin, AAPCHO

Reviewers:

Stephen Jiang, AAPCHO
Chantal Raymer, AAPCHO

Kathy Lim Ko, Asian Health Services
Linda Okahara, Asian Health Services

Laurin Mayeno

Betty Lee Hawks, Office of Minority Health
Rizalina C. Galicinao, Office of Minority Health

Serena Chen

Layout:

Peter Ho, AAPCHO

Graphics:

John Nguyen, Design One

Printing:

Jacob Tran, J.T. Litho

List of Abbreviations

The Centers

AHP/THE	Asian Health Project, THE Clinic, Inc., Los Angeles (APHCV Site)
AHS	Asian Health Services, Oakland
APHCV	Asian Pacific Health Care Venture, Los Angeles
CHC	Chinatown Health Clinic, New York
CSC	Chinatown Service Center, Los Angeles (APHCV Site)
IDCHC	International District Community Health Center, Seattle
KHF	Koryo Health Foundation, Los Angeles (APHCV Site)
KKVHC	Kokua Kalihi Valley Community Health Center, Honolulu
NEMS	North East Medical Services, San Francisco
SCCHC	South Cove Community Health Center, Boston

Other Terms

AAPCHO	Association of Asian Pacific Community Health Organizations, Oakland
APIs	Asians and Pacific Islanders
LAP	Language Access Project
OMH	Office of Minority Health, Department of Health and Human Services

EXECUTIVE SUMMARY

As U.S. society becomes more ethnically diverse, the question of how to ensure access to health care services for people with different language and cultural backgrounds requires our close attention. Yet little work has been done to address the lack of language access, especially for Asian Pacific Islanders (APIs). For this reason, the Association of Asian Pacific Community Health Organizations (AAPCHO) carried out a project titled Development of Models and Standards for Bilingual/Bicultural Services for Asian and Pacific Islander Americans in 1992-93 with support from the Office of Minority Health, U.S. Department of Health and Human Services to examine how to make our health care system accessible to everyone.

Through this project, AAPCHO examined nine API community health center sites to identify ways to implement linguistically and culturally competent health care services in areas that have large Asian and Pacific Islander populations. This language access report describes the following:

- 1) characteristics of patients and communities served by the AAPCHO health centers,
- 2) organizational policies and practices ensuring accessibility for APIs, and 3) proposed language standards, guidelines and policy recommendations for ensuring language access for APIs.

Patient Population

Data collected indicated that about 97% of the patients at the AAPCHO health center sites were APIs. At eight of the sites, over 90% of the patients served in 1992 had limited-English speaking skills. Although the health centers served many patients in the surrounding area, a large number of patients travelled for more than 30 minutes to get to the health centers. Furthermore, as API populations rapidly increase in the metropolitan areas, the demand for primary health care services also increases and poses a tremendous challenge to the community health centers.

Organizational Policies and Practices

To ensure greatest accessibility to health care services, all AAPCHO sites strive to provide linguistically and culturally competent primary health care services. All of the health center sites provide primary and preventive care services to respond to health problems and needs for community members at all ages. They also provide outreach, health education, social services, and eligibility assistance for government-sponsored health coverage.

To make services linguistically and culturally accessible to their user populations, the health centers have bilingual and multilingual staff members, accounting for 66 to 93% of the staff at the health centers. By using the bilingual and multilingual staff members and outside interpreters from language banks, volunteers, and consultants in various capacities, the health centers strive to ensure language access at all points of patient contact. In addition, the health centers believe that effective communication with patients require a solid understanding of the patients' cultural beliefs and practices related to health care and an ability to interpret Western biomedical concepts in the patient's cultural framework and vice-versa. For this reason, the health centers made on-going efforts to understand patients' cultural beliefs and practices and to incorporate them into the clinical and other general services, such as health education.

Beyond the direct service delivery within their own facilities, the health centers identified access barriers and other health care problems facing community members as a result of a lack of linguistically and culturally competent health care services available in the current health care system. Depending on their organizational resources, the health centers provided, to varying degrees, patient advocacy

and interpretation services when patients were referred out to other organizations. Lastly, to provide services that are truly accessible to their community members, the health centers emphasized consumer representation in their governance structures, such as on the boards of directors.

Standards and Guidelines

On the basis of the findings of this study, we propose some minimum standards and guidelines for serving people with different language and cultural backgrounds. Minimum standards include:

- ✧ Informing patients of their rights to receive services in their primary languages.
- ✧ Ensuring language access at key points of patient contact; that is, services, communications throughout the clinical visit, and follow-up care should be provided in a manner accessible to patients with limited English skills.
- ✧ Ensuring that those who provide services to patients with differing language and cultural backgrounds have appropriate medical and cultural training, in addition to the applicable language skills.
- ✧ Ensuring that written materials and signs are available for the major language and cultural groups using the health care service facility.
- ✧ Extending language access beyond clinical services to include all services provided, such as health education, health promotion campaigns, and social services.
- ✧ Ensuring that the governing boards of health care organizations have consumer input and representation, and that consumer involvement is solicited in the organization's planning and evaluation of service delivery.

Maintaining these minimum standards requires the health care organizations to carefully analyze their patient populations, invest in staff recruitment and training, and make a continued commitment to providing services that are accessible to everyone. Some guidelines for health care providers include:

- ✧ Conducting periodic needs assessments of patients and community members at large, including the collection of data pertaining to demographic, linguistic, and cultural characteristics.
- ✧ Exploring various referral sources to ensure that patients have access to adequate and appropriate health care.
- ✧ Developing a long-term employment plan to increase the hiring of bilingual/bicultural and multilingual/multicultural health care professionals.
- ✧ Hiring personnel with appropriate language skills and cultural knowledge and offering in-house training of culturally competent service delivery to ensure uniform, high-quality services.
- ✧ Ensuring continued efforts to add to the knowledge base of linguistically and culturally competent health care practices by conducting research, exchanging information with other providers serving similar populations, and maintaining open communication channels with community members.

RECOMMENDATIONS

To develop a health care system that is linguistically and culturally accessible to API populations, the federal and state governments should initiate actions in the following three areas: 1) enforcement of civil rights laws, 2) expansion of community-based infrastructure and 3) proper needs assessments of underserved APIs.

Recommendation 1: System-wide Responsibility Results of this project suggest a general lack of system-wide responsibility for providing health care services accessible to APIs with different language and cultural needs. Despite federal and state laws guaranteeing equal treatment, many APIs experience limited or blocked access to health care because of cultural and linguistic differences. To address this problem, AAPCHO recommends that federal and state governments establish stricter regulations for equal care and effective monitoring mechanisms.

Recommendation 2: Community-based Infrastructure This project reveals that the community health centers serving API populations have had limited capacity to address the increasing needs of the community. AAPCHO therefore recommends that the community-based infrastructure delivering linguistically and culturally appropriate services be strengthened by providing financial and technical support for existing programs as well as program development activities related to language and cultural access.

Recommendation 3: Data Collection and Analysis This study demonstrates that current approaches to identifying primary care needs based on geographic units often fail to identify the health needs of API communities. This is aggravated by a lack of data on API health status as well as the availability of providers to serve API communities. AAPCHO recommends that the government increase its efforts in 1) developing adequate methodologies that overcome the language and cultural barriers faced by medically underserved populations and 2) studying medically underserved APIs to increase our understanding of the health care needs and barriers to access of these populations.

Figure 1

The migration of Asians and Pacific Islanders (APIs) to the United States since the mid-1960s has dramatically changed the demographic landscape of America. During this time, the API population increased by more than 400 percent, from 1.7 million in 1970 to 7.3 million in 1990 - the fastest rate of growth of any ethnic group.¹ (see Fig. 1).

Despite this rapid growth during the past two decades, Asians and Pacific Islanders remain the most poorly understood minority group in the U.S. in terms of health status and health care utilization. This may be attributed to many factors including heterogeneity of APIs, aggregation of data and lack of data on specific API ethnic groups.

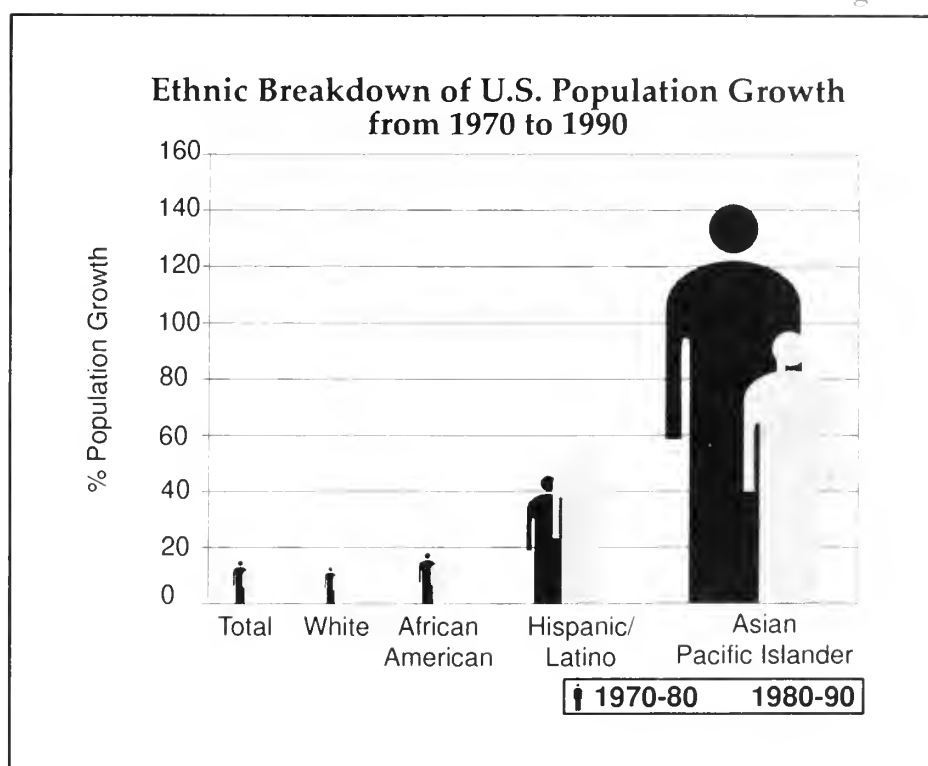


Figure 2

H

ETEROGENEITY

Income- 1990 Census showed that Southeast Asian groups had average annual per capita incomes ranging from \$2,692 for Hmong to \$9,032 for Vietnamese. The average annual per capita income for Japanese was over \$19,000 compared with the national average of \$14,143.

Employment- In 1990, Asian American adults (16 years old and over) had lower unemployment rates than the US adults overall; however, among some Asian American groups i.e., Laotians, Cambodians, and Hmong, the unemployment rate was much higher than the national rate.

Health Status- Although available data show that Asian Americans have longer life expectancy, lower death rates, and lower infant mortality rates; Asian refugees suffer higher rates of tuberculosis and hepatitis B than the US population and, as a whole, experience more nutritional and mental health problems.

Heterogeneity

APIs are very diverse in terms of ethnicity, language, and cultural background. There are 28 identifiable Asian and 19 Pacific Islander ethnic groups reported in the U.S. Census (see **Appendix A**) who speak more than 100 different languages and dialects. This extremely heterogeneous group is also characterized by a bipolar pattern in some socioeconomic and health indices; in fact, the model minority myth of APIs as the "successful" minority masks the reality of a large segment of the API immigrant population who live below the poverty level and face many social and health needs (see Fig. 2)².

Aggregation of data into one category

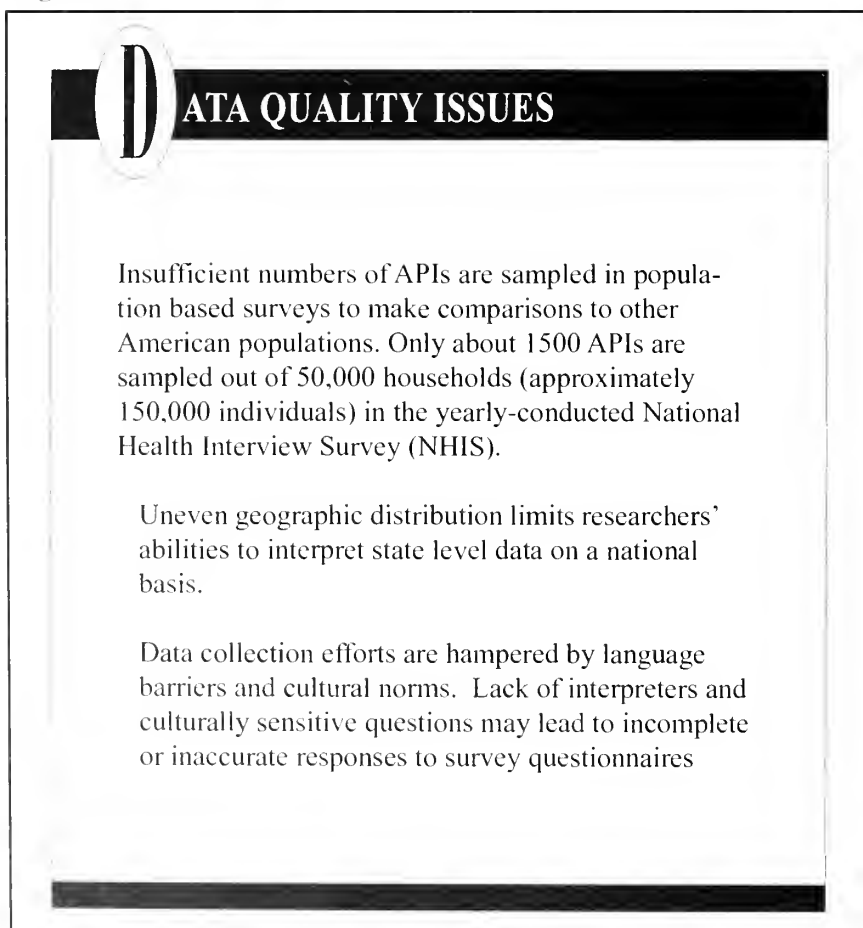
National health care surveys, including the National Health Interview Survey, have historical-

ly aggregated or “lumped” all Asians and Pacific Islanders into one category despite the diversity. In some cases, APIs are even put in the “other” category). This aggregation hides the significant health problems that specific API ethnic groups face.

Lack of data

In 1985, when the Secretary’s Task Force Report on Black and Minority Health was released, it consistently described health data for APIs as either “very limited” or “sparse.”³ Despite some local data which have revealed specific health problems for APIs such as hypertension, cancer, diabetes, tuberculosis, and hepatitis B, there still remains a lack of data for many API groups (see Fig. 3).

Figure 3



CASE STUDY 1:

Ms. L, AAPCHO Health Center Patient

Ms. L, a Korean immigrant, was diagnosed with chronic back pain and an ulcer. She recounts, “...doctors at [AAPCHO health center] refer me to [the county hospital] to have a special test. I would rather die than keep going to [the hospital]. First of all, I have to wake up early in the morning and leave home about seven o’clock for the hospital. And I wait and wait, and have a special test. I come home around four o’clock... I usually go to [the hospital] on Tuesday, but Korean translators are not always available. I think it takes only ten minutes to have a special test, but I have to wait five to six hours for that ten minutes.

BARRIERS TO ACCESS: DEFINITION OF PROBLEM

Despite a multitude of health problems, many APIs lack access to comprehensive health care because of financial, linguistic, and cultural barriers. Financial barriers affect a significant portion of the population, resulting in minimal or no health coverage.⁴ In 1990, the poverty rate among APIs exceeded that of whites by 43 percent. The Asian/Pacific Islander Data Consortium (ACCIS) reported that 28.0 percent of all APIs under the age of 25 had incomes less than \$5000, the highest rate of any racial group.⁵ Mayeno and Hirota reported that cer-

Figure 4

tain API ethnic groups (34.7 percent of Laotians, 42.6 percent of Cambodians, and 63.6 percent of Hmongs) had higher poverty rates in 1990 than the national poverty rate of 13.0 percent⁶ (see **Fig. 4, 5**). The rate of APIs under age 65 without insurance exceeded that of whites by 61 percent in 1989. Furthermore, for the many APIs working in the small-business sector, employment-based insurance is often unavailable or severely inadequate.

The lack of linguistically accessible services also presents a barrier for APIs in seeking and obtaining needed health care services. Without multilingual services, many APIs cannot gain access to primary health care.^{7,8,9} The lack of culturally competent services is also a major obstacle for patients in defining, evaluating, and presenting problems to health care providers. As a direct result of miscommunication or a provider's lack of knowledge of a patient's cultural beliefs, many patients are less likely to seek routine preventive health screening, maintain prescribed regimens, or comply appropriately to treatment plans.^{10,11,12,13}

LITERATURE REVIEW

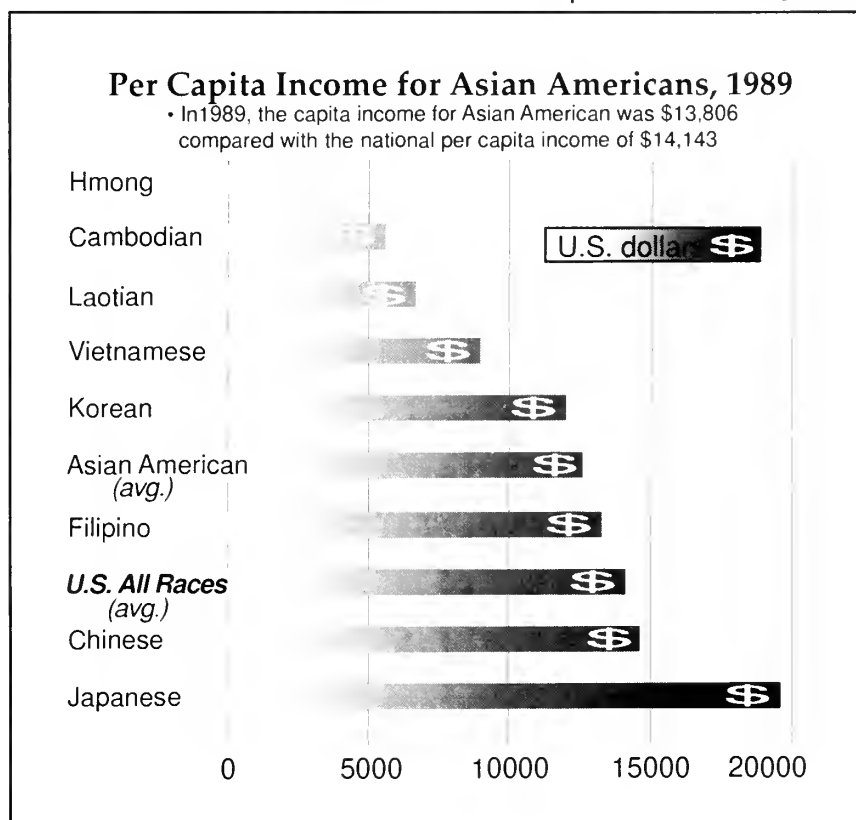
Several journal articles have described the linguistic and cultural barriers to getting access to health care for immigrants.

Most recently, Woloshin and colleagues (1995) described steps to overcome language barriers in a health care setting and identified language legislation in states with large limited-English proficiency (LEP) populations. Other authors like Faust and Drickey (1986) and Slomski (1993) described the challenges in working with interpreters in multilingual settings. Vera and Perkins (1995) gave an overview of the legal requirements to ensure language access.

However, a literature review of Medline from 1975 to 1996 revealed few studies describing the challenges of ensuring language access specifically in the API community and no studies detailing language access models for APIs.



Figure 5



OVERVIEW OF AAPCHO AND ITS HEALTH CENTERS

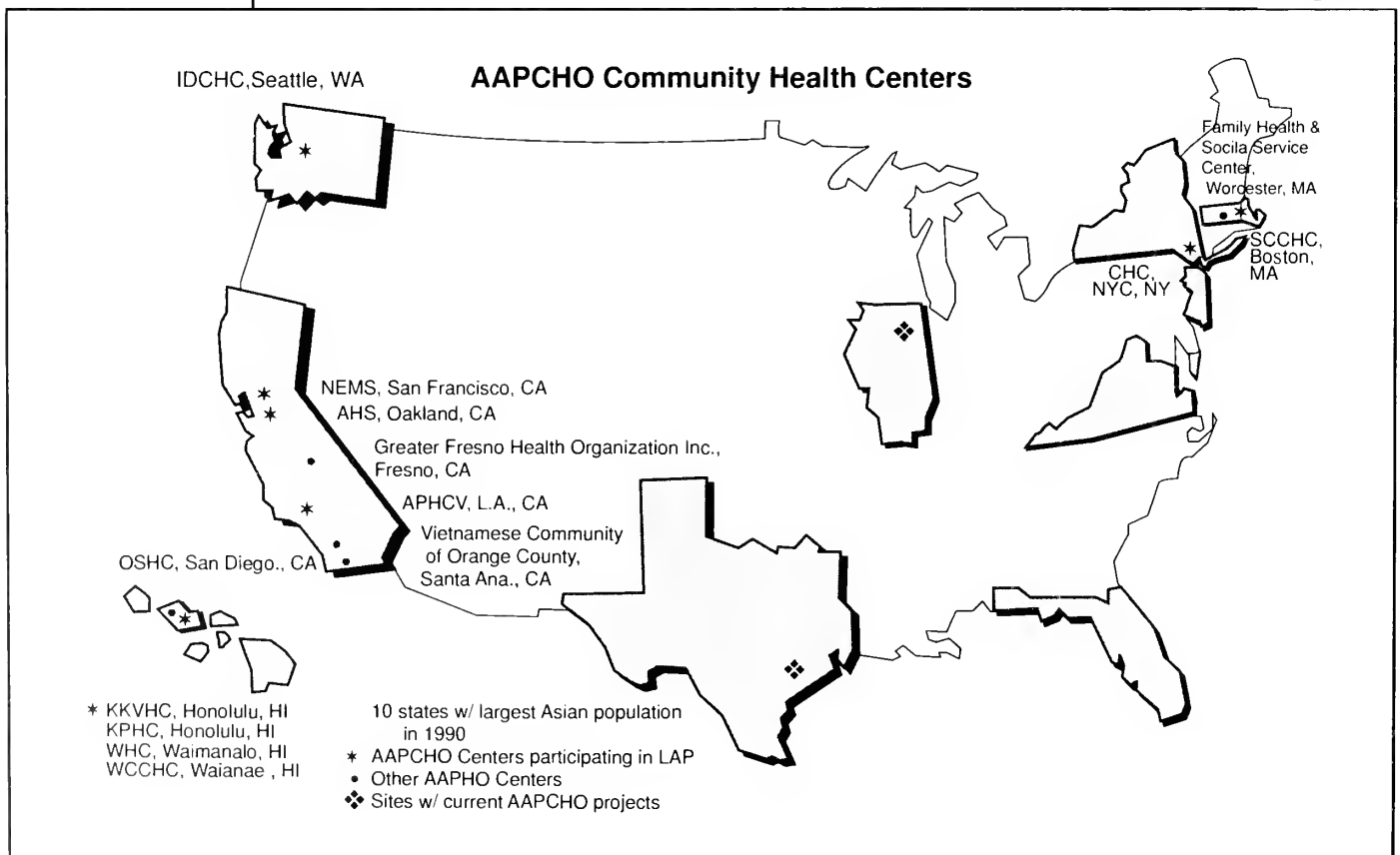
The Association of Asian Pacific Community Health Organizations (AAPCHO) currently consists of 14 community health centers (see Fig.6). The following seven health centers participated in the project.

- ∞ Asian Health Services (AHS) in Oakland, California
- ∞ Asian Pacific Health Care Venture (APHCV) in Los Angeles, California
- ∞ Chinatown Health Clinic (CHC) in New York City, New York
- ∞ International District Community Health Center (IDCHC) in Seattle, Washington
- ∞ Kokua Kalihi Valley Community Health Center (KKVHC) in Honolulu, Hawaii
- ∞ North East Medical Services (NEMS) in San Francisco, California
- ∞ South Cove Community Health Center (SCCHC) in Boston, Massachusetts

The Asian Pacific Health Care Venture in Los Angeles, has three service sites (Chinatown Service Center, Koryo Health Center, T.H.E. Clinic/Asian Health Project), each with distinct patient and service characteristics. Therefore, the term health center sites is used to refer to the total of nine participating sites. The other seven AAPCHO centers were not described in this report because they became members after the study was completed.

Many of the AAPCHO health centers were formed in the late 1960s and early 1970s to address the financial, language and cultural barriers in health care facing the API communities.[‡] The health centers are comprehensive community-based primary care providers that offer linguistic and culturally-responsive services. Each health center assumes responsibility for managing the total care of their patients and, as a result, plays a crucial role in patient advocacy and expediting referrals from other medical providers.

Figure 6



[‡] The exception to this is the Asian Pacific Health Care Venture in Los Angeles, which was established in 1986 and several newer AAPCHO centers.

Figure 7

The AAPCHO health center sites are at the forefront of providing care to the low-income, medically indigent segments of the Asian population including many recent immigrants, refugees and their families who still have a need for culturally appropriate services. It also includes Pacific Islanders who, although considered U.S. nationals or citizens, have unique linguistic and cultural characteristics and health care needs.

LEGISLATIVE BACKGROUND

Although many of these community health centers have provided a range of multilingual and multicultural[†] primary care services to underserved API populations for more than 20 years, formal documentation of how their services impact the populations' access to health care remains scarce. In response to this need, the Office of Minority Health (OMH) funded the AAPCHO in 1992 to initiate a project entitled *Development of Models and Standards for Bilingual/Bicultural Services for API Americans*, referred to in this report as the Language Access Project.

The Language Access Project was designed to address the critical lack of standards, guidelines and policies for the implementation of language access and culturally competent service delivery within a primary care setting (see **Fig. 7, 8**). The absence of standards and guidelines has hindered the federal government's ability to ensure that the programs it funds are both linguistically accessible and culturally appropriate to the target populations. In an initial yet crucial step, the Language Access Project will provide some preliminary policy recommendations on improving language access for the Asian and Pacific Islander community.

[†] The broad term multilingual/multicultural is used to encompass bilingual/bicultural individuals and services as well as those that cover more than two languages and cultures.

LEGISLATIVE DIRECTIVE FOR LANGUAGE ACCESS PROJECT

The Language Access Project responds to legislative mandate P.L. 101-527, Section 17078 (b) (7) of the Disadvantaged Minority Health Care Improvement Act of 1990, which authorized the Office of Minority Health (OMH), Department of Health and Human Services, to provide funding for public and non-profit private entities for multi-lingual assistance in the provision of health care.

Figure 8

CIVIL RIGHTS ACT OF 1964

The Office for Civil Rights (DHHS) views inadequate interpretation as a form of discrimination under the Civil Rights Act of 1964, which states that "no person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination" under any federally supported program. The office also requires DHHS-funded health programs (e.g. Medicaid, Medicare) to provide patients with limited English skills access to services equal to those provided to English speakers.

References:

1. U.S. Bureau of the Census 1990.
2. Chen MS and Hawks BL. "A Debunking of the Myth of Healthy Asian Americans and Pacific Islanders." *American Journal of Health Promotion*. Vol.9, No.4, pp. 261-268, March 1995.
3. US DHHS, Secretary's Task Force on Black and Minority Health . 1985.
4. Chen A and Mayeno L. "Developing a Uniform Data Base Among Community Health Centers, June 1989. Unpublished document prepared by the Association of Asian Pacific Community Health Organizations.
5. Asian/Pacific Islander Data Consortium, *Asian and Pacific Islander Americans: A Profile of Socioeconomic Characteristics-1990:Profile Series 3-United States of America*, San Francisco, CA, 1992.
6. Mayeno L and Hirota S. "Access to Health Care" in N Zane et al (eds) *Confronting Critical Health Issues of Asian and Pacific Islander Americans*. Sage Publications. Thousand Oaks, 1994.
7. D'Avanzo C. "Barriers to Health Care for Vietnamese Refugees." *Journal of Professional Nursing*, Jul- Aug 1992, pp. 245-253.
8. Haffner L. "Cross-Cultural Medicine A Decade Later: Translation is Not Enough." *The Western Journal of Medicine*, 152, September 1992, pp. 53-59.
9. Putsch R. "Cross-Cultural Communication: The Special Case of Interpreters in Health Care." *Journal of the American Medical Association*, 254, December 1985, pp. 2244-2248.
10. Hoang GN and Erickson RI. "Guidelines for Providing Medical Care to Southeast Asian Refugees." *Journal of the American Medical Association*, 248 (6), August 1982, pp. 710-714.
11. Kleinman A, Eisenbert L and Good B. "Culture, Illness and Care: Clinical Lessons from Anthropologic and Cross Cultural Research." *Annals of Internal Medicine*, 88, 1978, pp. 251-258.
12. Mueke MA, "In Search of Healers: Southeast Asian Refugees in the American Health Care System." *Western Journal of Medicine*, 139, December 1983, pp. 835-840.
13. Putsch R. "Dealing with Patients from Other Cultures," from Walker, Wall and Hurst: *Clinical Methods*, 3rd Edition, Boston: Butterworths, 1990, pp. 1050-1065.

CHAPTER II: AAPCHO CENTERS' USERS AND OPERATIONS

PURPOSE OF STUDY

Hypotheses

The hypotheses for this project are:

1. AAPCHO centers provide effective and culturally-appropriate models of multilingual and multicultural health service delivery.
2. Despite the AAPCHO models, there still remain unmet cultural and language access needs in the health centers due to capacity limitations.

Objectives

Specific project objectives are:

1. To identify and document models for the provision of multilingual primary care services to Asians and Pacific Islanders.
2. To identify various costs associated with providing multilingual services at AAPCHO centers.
3. To develop guidelines and minimum standards for multilingual/multicultural services.
4. To provide recommendations for policymakers about ensuring the provision of multilingual services for APIs in a managed care environment.

This report is divided into three parts:

- 1) AAPCHO Centers' Users and Operations
- 2) Financial Issues Related to Language Access
- 3) Impact of Managed Care Environment on Language Access

METHODOLOGY

The AAPCHO centers provided the following information for this project:

AAPCHO Centers' Users

1. definition of primary and secondary service areas
2. patient origin data by census tracts
3. maps outlining the geographic distribution of users
4. population data on the ethnic composition of their service areas
5. ethnic composition of health center users and encounters[♦] in 1991.

AAPCHO Centers' Operations

1. Supplementary materials including mission statements, organizational charts and brochures, board membership lists, and inventory of health education materials.
2. A working meeting involving AAPCHO center staff was held in April, 1993. During this meeting, center staff elaborated on the questionnaires and added critical information and perspectives. The group also developed a set of guidelines and standards for multilingual/multicultural primary health care services.

A written questionnaire was completed by each AAPCHO center and provided the following information:

1. Data from 485 patients on factors influencing their decision to seek care at the health centers, including a) language spoken by staff; b) quality of medical care; and/or c) proximity of health center to patient's home.
2. Comprehensive information related to language access services and cultural competence including health centers' services, mission, policies, procedures, structure, staffing, staff development and costs.
3. Staff identification sheets, which required listings of identifiers, ethnicities, job functions, and language capabilities of all staff members

[♦] The term encounter refers to a face-to-face meeting with a provider

and patient flow sheets that described how language access was provided at each point of patient contact. Translated materials used (e.g., informed consent forms, clinic forms, patient histories) were also included.

Limitations

1. *Focus on qualitative and anecdotal information.*

Although much of the data is qualitative rather than quantitative, it provides a detailed overview of the language access issues related to the users and operations of the participating AAPCHO health center sites.

2. *Limited discussion on cultural competency.*

Although cultural competency incorporates aspects of linguistic accessibility, there is more detailed information on this topic in other journal articles and reports. Since the focus of this report is more specifically on language access, the discussion on cultural competency was kept brief.

FINDINGS ON AAPCHO CENTERS' USERS

This section describes and analyzes the users, defined as registered patients, served by the health centers. Ethnic and language characteristics of health center users are documented to demonstrate the need for linguistically and culturally appropriate services.

The descriptions of the geographic areas served document the distances over which health center users live. This section also explores reasons that patients give for seeking the services of the participating health centers.

Ethnic Composition

Asian and Pacific Islander patients comprise 89 to 99 percent (mean of 97 percent) of all users at each health center site. The limited English-speaking population at eight of the nine sites

ranges from 91 to 99 percent (mean of 95 percent). Honolulu's KKVHC has a 40 percent limited English-speaking population. The high proportion of limited English-speaking users supports the need for linguistically accessible services.

Five of the health center sites (New York's CHC (Chinese), Los Angeles' CSC (Chinese), Los Angeles' KHF (Korean), San Francisco's NEMS (Chinese) and Boston's SCCHC (Chinese)) serve one primary ethnic group each. On average, 95 percent of patients at each of these centers are from one ethnic group.

Each of the other four health center sites (Los Angeles' AHP/THE, Oakland's AHS, Seattle's IDCHC, and Honolulu's KKVHC) serves several major ethnic groups. KKVHC users are equally distributed between Filipino (33 percent) and Samoan (33 percent), followed by Laotian, Hawaiian, and Vietnamese. The majority of IDCHC users are Chinese (42 percent) followed by Filipinos, Vietnamese, Koreans, Laotians and Khmer. AHS has a high concentration of Chinese (65 percent), but also serves Koreans, Vietnamese, Laotians and Filipinos. The majority of AHP/THE's users are Thai (58 percent) followed by Japanese, Filipinos, Tongans and Laotians. (see Fig. 9, 10).

Primary and Secondary Service Areas

Service areas[†] of the health centers are defined by fixed boundaries and identifiable ethnic populations of medically underserved and low-income persons.

Most of the health centers' service areas are spread over large dispersed geographic areas. Health center users are located in large and small clusters in the service area. Health centers reported that 10 to 70 percent of patients live more than 30 minutes from the health center. Data suggest that patients travel long distances from dispersed areas to receive health center services and will continue to use the health centers for medical treatment long after they have moved from the primary service area.

[†] Service areas are formally designated areas served by a specific health center. The primary service area refers to the area where approximately 80 percent of the patients reside. The secondary service area is the area in which the remaining 20 percent reside. The majority of health centers participating in this project target a specific service population within the designated service area.

Figure 9

Examples of centers serving API populations who may need to travel long distances in dispersed areas include the following:

☞ Oakland's AHS has two census tracts located in the city of Oakland that comprise roughly 80 percent of its user base. Up to 20 percent of its users are dispersed throughout the rest of Alameda County.

☞ The APHCV is a consortium of three health center sites (AHP/THE, CSC, and KHF) in Los Angeles County. Each health center site is located in concentrated API districts of Los Angeles; however, many patients are from different pockets and clusters throughout the county. In many cases, patients cross the entire county to obtain services.

☞ In New York City, only 30 percent of patients come from Manhattan (where CHC is located), while 70 percent of CHC patients travel from the other four boroughs (Queens, Bronx, Brooklyn, and Staten Island). Travel to CHC from other boroughs by public transportation takes more than an hour, on the average.

☞ NEMS has a sizable number of patients living in their service area in San Francisco. Approximately 10 percent of its users live outside city limits in neighboring San Mateo and Santa Clara Counties, which for some is 40 to 50 miles from NEMS.

☞ SCCHC patients often travel 17 to 20 miles from nearby towns in the Boston metropolitan area.

Reasons for Using Health Centers

The reason most frequently given for using the health center sites is that staff spoke the patients' languages (approximately 40 percent). More than one-third of the patients said the health centers provided good medical care. Patient preference based on quality of care could imply that services were culturally appropriate.

Markedly fewer patients said they used the health centers because of the center's proximity to their homes (approximately 15 percent).

SERVICE LANGUAGES OF HEALTH CENTERS								
LANGUAGE	AHS	CSC	AHP/ THE	KHF	CHC	IDCHC	KKVHC	NEMS SCCHC
Burmese						X	X	X
Cantonese & Mandarin	X	X			X	X	X	X
Other Chinese* dialects	X	X	X		X	X	X	X
Hmong						X		X
Japanese	X		X				X	X
Khmer	X		X			X		X
Korean	X		X	X		X		X
Laotian	X					X	X	
Mien	X					X		
Samoan						X	X	
Spanish	X	X	X	X				X
Tagalog & Ilocano	X		X			X	X	X
Tibetan						X		
Thai	X		X			X	X	X
Tongan			X			X	X	
Vietnamese	X	X	X		X	X	X	X
Visayan	X						X	

* Centers provide one or more of the following Chinese dialects: Chaozhou, Fujianese (Fukien), Hakka, Minnan (Taiwanese), Shanghainese, & Toisan.

Figure 10

As of 1993, the primary ethnic groups served at various AAPCHO health center sites are Chinese, Filipinos, Vietnamese, Koreans, Samoan, Thai, Hawaiian and Laotian. However, AAPCHO sites are expanding their services to other API groups.

This finding is consistent with patient origin data, which shows that patients' homes are spread over large geographic areas. Further, anecdotal information suggests a lack of linguistically accessible and culturally responsive health services in users' neighborhoods. Thus patients are willing to travel long distances to obtain appropriate care.

Unmet Needs

Unmet needs for APIs in health center service areas include a) large API populations that are not receiving health center services and b) low capacity and limited resources of health centers to provide services to increasing needs of APIs in their service areas.

Information provided by the health center sites points to an unmet need for primary health care among APIs in their respective service areas.

Figure 11 shows that the numbers of APIs in the service areas are far greater than the number of API health center users. It is evident that many APIs are not receiving services from

the health centers. Additional variables, such as socioeconomic and health status, insurance status, and provider availability, must be considered to assess this unmet need more thoroughly.

Anecdotal information from the health centers, lengthy waiting lists and requests by community groups to provide services, suggest that many APIs lack access to primary care services. Because the health centers operate at full capacity, their ability to respond to this need generally depends upon efforts to increase capacity. This increased capacity may include expanding the number of patients served or adding services for previously unserved ethnic or language groups.

Examples of health center efforts to identify and meet unmet needs in 1992 include the following:

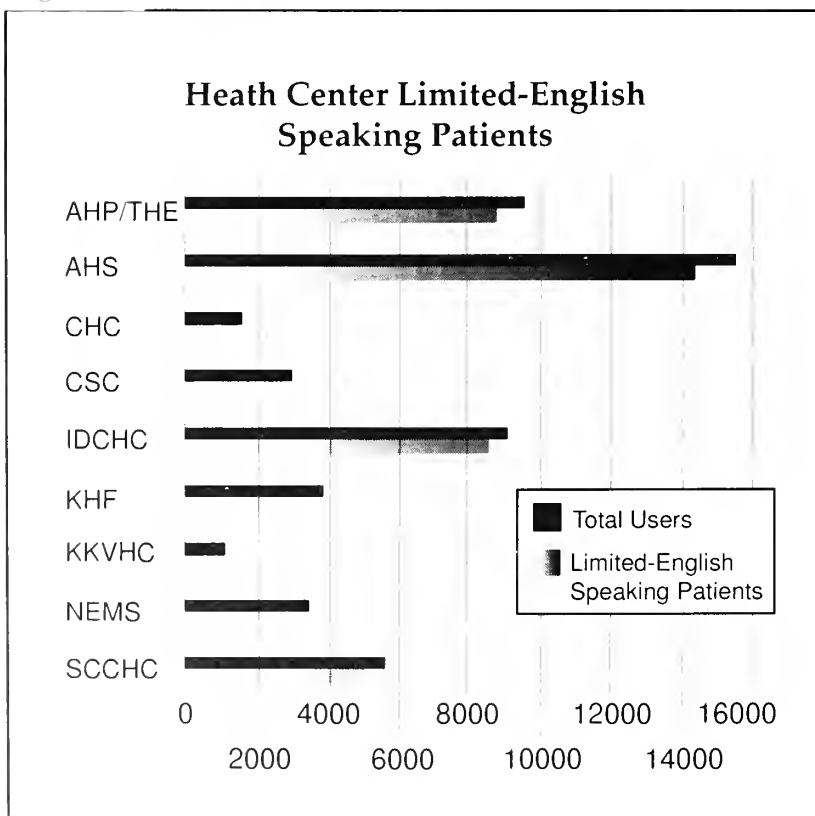
- ✧ Oakland's AHS instituted a moratorium on new patients in April 1992 as a result of a 7-month waiting list for initial medical appointments. AHS had a list of 2,000 people who sought to register as new patients during the moratorium. During the moratorium, only pregnant women, HIV-positive individuals, people with chronic illnesses, and referrals from other providers were accepted as new patients. An expansion of services is planned in order to serve more patients.

- ✧ Los Angeles' APHCV has difficulty addressing the needs of all API ethnic communities because of the dispersed and large populations. Nonetheless, it is specifically targeting new efforts to serve the Khmer and Samoan communities. APHCV hopes to conduct a needs assessment but lacks the resources for this purpose.

- ✧ New York's CHC is expanding to meet the needs within the Chinese community. They have established an agreement with another health center in Brooklyn to work collaboratively in meeting the needs of the Chinese community in Brooklyn.

- ✧ Seattle's IDCHC has identified the need to reach out to limited English-speaking Laotians, Tongans, and Cham (ethnic group from

Figure 11



Vietnam); plans are underway to initiate outreach to these populations in response to this need.

☞ San Francisco's NEMS increased services to pregnant women needing prenatal care. However, as a result of limited space, it became necessary to increase the number of clinical hours which often results in providers staying late into the evening. Patient waiting times have also increased to as long as an hour.

In summary, the health centers have stretched their capacity to respond to growing needs among APIs in their service areas. Insufficient resources and limited capacity have hindered their ability to keep up with this growing need. Therefore, large numbers of APIs in their service areas still lack access to primary care services.

FINDINGS ON AAPCHO CENTERS' OPERATIONS

This section identifies the key components of the linguistically and culturally accessible services provided by the participating health center sites and is intended to assist health care providers who are serving or are planning to serve similar populations with conceptualization and development of their services. It is also designed to assist policy-makers and planners in understanding the issues involved in providing services to API populations. (For a more detailed description of the AAPCHO centers, see **Appendix B**)

Mission and Goals

Several themes consistently run through the stated mission and goals of the participating health centers:

Population Served. Every health center serves a patient population which is predominantly Asian and/or Pacific Islander and identified based on ethnicity and/or geography.

Language/Cultural Access. Most of the centers' mission statements explicitly mention improving access or reducing barriers to access as a

goal. Several state that their mission is to provide care that is multilingual, multicultural, or culturally competent.

Services Provided. Most of the mission statements include the provision of affordable, quality primary care. Several also explicitly identify community health education as an area of focus.

Health Rights. Three health centers (AHS, CHC, and IDCHC) specifically state advocacy or exerting efforts to affect policy as a way to promote health rights and improve access to health care. Two centers (AHS and CHC) mention advocating for or upholding the community's health rights by educating and organizing communities.

Language Access Policy. Four health centers (AHS, APHCV, CHC, and NEMS) have an explicit or implicit policy within their organizational mission to provide language access to the populations they serve.

Services Provided

All of the health center sites provide basic primary care services for all stages of the life cycle from perinatal care to pediatrics to adult and geriatric health. The health center sites' services extend beyond medical care to include outreach, education, social services, and eligibility assistance for government-sponsored health coverage. (See **Fig. 12**) for services provided by each health center site)

In addition to the basic services provided at all sites, the following services are provided at several sites: dentistry, optometry, mental health, laboratory, and nutrition. A few sites also provide podiatry, pharmacy, and radiology. Acupuncture is currently provided only at San Francisco's NEMS.

Prevention and Continuity. The health center sites emphasize comprehensive care, which includes a strong prevention focus and an emphasis on case management. This approach allows staff to coordinate care for an individual and/or family, ensure appropriate follow-up, and enhance continuity of care.

Community/Population-Based Model. The health centers are designed to respond to the health problems and needs endemic to their communities. There is an emphasis on health problems common to Asians and Pacific Islanders, such as hepatitis B and tuberculosis. The centers conduct community-wide education and awareness campaigns that are geared toward improving the health of the community as a whole.

through the consortium. Some of the fiscal and administrative functions are also conducted by the consortium.

APHCV is a consortium that serves as an umbrella organization for three health center sites (AHP/THE, CSC, and KHF) in Los Angeles. However, these three sites are separate organizations, each with a distinct mission, governance structure, management, and range of services. AHP/THE is a project that serves Asians and Pacific Islanders within a larger multicultural health center. CSC is a multi-service agency that provides health care, social services, and job training services to the Chinatown community. KHF is a health foundation that serves primarily Korean patients. These three health center sites receive primary care funding and provide primary care services under sub-contract to APHCV.

Governance and Consumer Involvement

All of the participating health centers are governed by boards of directors that determine the goals and direction for the organization. The health centers have been successful in developing boards of directors which are reflective of the populations served and meet the federal requirement to be community-controlled by having a minimum of 51 percent patient representatives. Most of the members represented on the ten governing boards are APIs (89 percent)[†] and bilingual or multilingual (68 percent). The boards also have a strong representation of consumers who comprise the majority on all but three of the boards (Los Angeles' APHCV, Los Angeles' CSC, and Seattle's IDCHC). For historical reasons, the APHCV board consists primarily of community agency representatives; however, APHCV is currently in the process of restructuring its board to increase involvement of users and other community members. IDCHC is also currently developing strategies for consumer participation on the board. All three (APHCV, CSC, and IDCHC) involve consumers in program development and implementation through advisory boards and in the review of program-related materials.

Organization

Of seven participating non-profit health centers, five are free-standing community health centers (Oakland's AHS, New York's CHC, Honolulu's KKVHC, San Francisco's NEMS, and Boston's SCCHC). Each of these centers provides its services as a distinct entity, with its own governance and management structure.

Seattle's IDCHC is part of a local clinic consortium. Although IDCHC also has its own governance and management structure, much of its funding, activities and reporting are conducted

RANGE OF SERVICES PROVIDED

(At time of study - 1993)

SERVICE	AHS	CSC	AHP/THE	KHF	CHC	IDCHC	KKVHC	NEMS	SCCHC
Primary Medical Care	X	X	X	X	X	X	X	X	X
Perinatal Care	X	X	X	X	X	X	X	X	X
Pediatrics	X	X	X	X	X	X	X	X	X
Family Planning	X	X	X	X	X	X	X	X	X
Nutrition	X	X	X	X	X	X	X	X	X
Dental Care						C	X	X	X
Optometry								X	X
Podiatric Care						X		X	X
Acupuncture								X	
Mental Health		X				X			X
Adolescent Clinic	X		X	X				X	X
Laboratory Services	C	C	C	C	X	X	X	X	X
Pharmacy Services	C					X		X	
Radiology Services	C			X	X			X	
Social Services	X	X	X	X	X	X	X	X	X
Health Education	X	X	X	X	X	X	X	X	X
Community Outreach	X	X	X	X	X	X	X	X	X
Referrals	X	X	X	X	X	X	X	X	X

Note: C denotes Contracted Service provided

[†] The ten boards include the nine health center sites and the board of the Asian Pacific Health Care Venture, the umbrella for the three sites in Los Angeles.

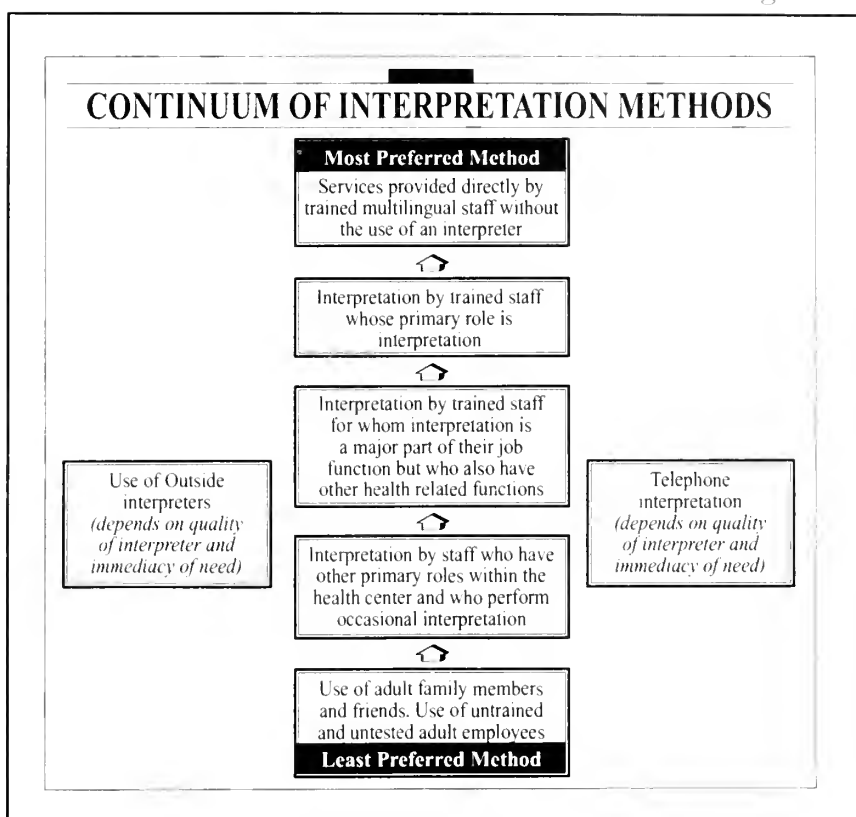
Figure 13

Methods of Ensuring Language Access

The participating health centers deliver their services in a manner that is linguistically accessible to the populations they serve. To achieve this goal and to facilitate effective communication with patients at all points of contact, personnel fluent in the patient's primary language are involved in all aspects of service delivery.

All of the health center sites employ bilingual or multilingual direct service providers who can communicate directly with the patient in his or her primary language (or another language in which he or she is fluent). When direct service providers do not speak the patient's language, the sites use interpreters.

Since most of the health center sites provide services in multiple languages and/or dialects, they must employ a variety of methods for ensuring language access at all points of patient contact. The "methods" below describe how language access is provided.



The best method for interpretation is to have bilingual/multilingual staff in key clinical positions.

Clinical Interpretation

The "continuum" of interpretation methods (see Fig. 13) in the clinic setting varies considerably. The specific use of each method depends upon various factors, such as the number of patients from any language group and the availability of staff with specific language skills. (The use of these approaches, however, is fairly consistent among health centers). Health centers that rely heavily on the use of interpreters during clinical encounters are Los Angeles' AHP/THE, Oakland's AHS, and Seattle's IDCHC.

The best method for interpretation is to have bilingual/multilingual staff in key clinical positions, while the least preferred method is to use

untested adult family members and friends. The use of minors and young children to interpret is unacceptable.

1. *Services provided directly by bilingual/ multilingual staff without the use of an interpreter.* This method involves the use of multilingual staff to provide services to patients with various language needs. These staff members, which include clinical providers, have direct contact with patients. Approximately 80 percent of clinical encounters at the participating health center sites are conducted by clinical providers who speak the patient's language. The sites prefer this method because it allows for direct communication without the use of a third party. The best method for interpretation is to have bilingual/multilingual staff in key clinical positions.

CASE STUDY 2:

Laotian female, Long Beach, CA

A pregnant Lao female needed to be induced. When the physician informed her of her condition, she was extremely scared and her husband and family refused to allow her to be induced. The community health worker asked the physician to take some time to explain in detail why she needed induction, then to allow the family some time to think before discharging the patient. The physician, community health worker/translator, patient, husband, uncles, and other family members then discussed the situation to make a decision. The physician spent much time explaining why the induction was needed, what an induction is, how the patient would feel, and what would happen to the baby. After much deliberation, the family decided to proceed with the induction. Both the induction and labor were successful. The husband later told the physician, "When you first told me, it sounded too scary, but after, it's not so scary."

Some sites rely heavily on multilingual staff due to the multiple service languages, diverse patient population, and the relatively small size of health center sites. These individual staff members, who speak several languages and/or dialects, in addition to English, enable centers to meet the needs of several language groups without having to hire several bilingual staff members.

Some sites have staff who speak these primary language groups at all points of patient contact. For patients speaking these languages, an interpreter is rarely, if ever, required within the health center. For example, the majority of San Francisco's NEMS patients speak one Chinese dialect (Cantonese). Although NEMS also provides services in other dialects and languages, several staff at each point of patient contact speak Cantonese. Similarly, Los Angeles' KHF serves a predominantly Korean population, and Korean is spoken by most of the staff.

New York's CHC also states that if a Chinese patient speaks a dialect other than those spoken

by staff, written Chinese may be used for communication. This is possible because the Chinese language is the same in written form although spoken dialects differ significantly.

In some situations, the interpreter may be the only person speaking to the patient in his or her language. In such cases, the interpreter accompanies the patient during each of the various points of patient contact. In other situations, the interpreter may be needed for only some points of patient contact. For example, if the clinical provider and some of the direct service staff speak the patient's primary language, interpreters may be needed only at certain points of contact (e.g., nutrition, eligibility screening). The primary situations in which interpreters are needed or used are described below.

2. Interpretation by staff whose primary role is interpretation. At Oakland's AHS, the need for interpretation has increased to the point where medical interpreters on staff serve primarily as interpreters. These individuals are also trained to perform basic job functions, such as reception and intake, thereby alleviating the need for a third party to perform these functions. This method allows staff members to develop expertise in the area of interpretation without other major job functions. Further, individuals dedicated to interpretation are less likely to have conflicts with other job duties when interpretation needs arise. This method is feasible only when there is a high demand for interpretation in the language(s) spoken by the staff person.

3. Interpretation by staff for whom interpretation is a major part of the job function but who also have other health-related functions. This category includes family health workers at Seattle's IDCHC and medical records clerks and caseworkers/translators at Oakland's AHS. This method is effective if the staff members have health/medical knowledge and are trained in interpretation skills. It allows organizations that do not have a high demand for interpretation in a particular language to create a position that fulfills limited interpretation needs as well as other duties. One disadvantage of this method is that conflicts sometimes arise between the staffing time needed for interpretation versus other job duties. In addition, the role of interpreter can conflict with other roles an individual may be hired for making it difficult for them to clearly understand their job responsibilities and priorities.

4. *Interpretation by staff who have other primary roles within the health center and who perform occasional interpretation.* Staff who have other primary functions within the health center are sometimes called upon to provide interpretation services. One disadvantage of this method is that it often interrupts the staff member's other responsibilities. Further, because interpretation is just one of several other job duties, staff may lack strong health/medical knowledge or interpretation skills. Therefore, their interpretation skills may be insufficient for exchanges involving complex health/medical concepts or patient instructions.

5. *The use of outside interpreters.* Most health centers use outside interpreters infrequently. Seattle's IDCHC has access to a multilingual language bank and uses interpreters from this language bank for language expertise not available through staff. Some health centers occasionally use volunteers and other outside consultants for interpretation services. These interpreters are trained in interpretation skills as well as knowledge of medical terminology and concepts. This approach allows centers to serve a specific language group if there is infrequent need for services in a particular language. However, the interpreter may not have an established relationship with clinical providers, which is crucial to effective interaction. Further, this service is not available to most of the health centers.

6. *Telephone interpretation services.* Only one site (Honolulu's KKVHC) reported using telephone interpretation services through a nonprofit organization established by local community agencies. The interpreters who provide these telephone services are trained in interpretation and in basic medical terminology and concepts. KKVHC also uses this service for health center patients referred or sent to the hospital.

Using telephone interpretation services as a source of interpretation may be appropriate for situations requiring brief and basic information exchange or in emergencies when a trained interpreter is not available. Telephone interpretation can also be useful for after-hours triage, which is normally conducted by telephone. But this method also has major limitations. Telephone interpretation services usually do not

specialize in health interpretation and may therefore lack the cultural understanding of the patient's health beliefs. As a result, such services do not usually provide the cultural interpretation needed for effective communication with patients.

7. *Using family members.* The health center sites stated that using patients' family members or friends as an interpreter is generally not acceptable. The use of this method has several potential legal and ethical implications. First, the health center cannot assume any responsibility for the accuracy and/or quality of the interpretation. Informed consent, which may be required for treatment, cannot be guaranteed. Further, the practice may result in a violation of patients' confidentiality. The risk of these potential problems increases when the role of interpretation is assumed by family members who are children. Some health care providers consider the use of young children as interpreters an unacceptable method of interpretation. Adult family members and friends are used as a last resort and only for minor services that do not require interpretation of complex or sensitive issues.

DISADVANTAGE OF USING FAMILY MEMBERS TO INTERPRET

Use of a family member may inhibit a patient from answering personal questions honestly. When the director of a county hospital's refugee clinic, examined a Vietnamese man while his daughter translated, he denied having any sexually transmitted diseases. But a week later, he returned to the clinic alone to tell the director he had a history of LGV and was worried it had come back.

Use of an untrained translator, while more objective than family members, may pose other problems. Unless trained in medical terminology, they are unlikely to know how to explain complex procedures. A physician asked a janitor to explain to a mother that her baby's worsening pneumonia made it necessary to intubate the infant. Embarrassed that he did not know what "intubation" was, the interpreter told her the baby had a heart problem.

C

ASE STUDY 3:

Mr. Y, Hmong, Fresno, CA

One night, a relative of Mr. Y's began to experience serious stomach problems. Though not proficient in English, his relatives were able to call for an ambulance. However, paramedics were unable to assess the relative's illness and provide treatment due to language barriers. Again, at the county hospital, there were no medical personnel proficient in Hmong. Consequently, the hospital staff could not provide treatment until Mr. Y was called in to interpret for his relative at 2:00 a.m. Although unfamiliar with Western medicine, Mr. Y related what he had been told to his relative about his medical condition and options. Surgery was scheduled for later that morning. Mr. Y left the hospital and was unable to return until 5:00 p.m., several hours after the surgery was completed. Even though the patient was literate in his native language, the staff had no written materials in Hmong as an alternative form of communication. Unable to convey post-surgical instructions to the patient, the hospital could not legally release him from the facility.

8. *Referrals to other agencies.* Occasionally, individuals who seek medical services speak languages not spoken by staff members. When this occurs, the health center staff seek the most appropriate way to obtain services for these individuals. For example, if another agency can meet the patient's language needs more appropriately, the patient is referred to that agency. This option often provides the most appropriate care for the individual. If care is to be provided at the health center, attempts are made to provide a qualified interpreter from a language bank or another agency. If no appropriate referral agency or outside interpreter is available, patients are asked to request an interpreter from another agency.

Impact on Clinic Flow

The nine health center sites reported that providing linguistically appropriate services impacts clinic flow by (1) requiring additional time in clinical visits (all sites); (2) increasing staff time waiting for an interpreter (prior to a clinical encounter) and patient time waiting (longer period in waiting room)(six sites); and (3) requiring changes in the sequence in which

patients receive care as a result of the need to match patients with staff possessing appropriate language skills (five sites).

In addition, three sites (Los Angeles' AHP/THE and CSC, and Honolulu's KKVHC) stated that telephone interpretation, cultural interpretation, and processing delays also affected clinic flow. Oakland's AHS and Seattle's IDCHC identified several scheduling challenges, including balancing unscheduled visits (triage), sick leave, and vacation time coverage; scheduling around planned and unplanned health center closures because of holidays; balancing medical needs and language needs[‡]; hiring/scheduling of receptionists to cover multiple languages by phone; and scheduling patient appointments according to language with an interpreter. The centers also reported that communication between multilingual clinical staff affected clinic flow.

Boston's SCCHC allows extra time for a patient needing an interpreter because the visit will take longer from start to finish. This is especially true with registering new patients (30 additional minutes) or elderly patients (10 additional minutes). Further, the interpreter's schedule does not always match the provider's at the time of the visit.

Health Education Materials and Interventions

The majority of the centers use a wide array of written and audiovisual health education materials in the patients' languages. Many health centers invest significant resources in the development of their own materials because quality health education materials are not available on many health topics in Asian or Pacific Islander languages.

Written materials. Most of the participating health centers use written health educational materials extensively and in conjunction with health education presentations and patient education. They are also distributed at health fairs and through other community channels. Los Angeles' APHCV, New York's CHC, and San Francisco's NEMS have lists of written educa-

tional materials, many of which they have developed themselves. Oakland's AHS, Seattle's IDCHC, and Boston's SCCHC have also developed several written materials in different languages.

Audiovisual materials. However, written materials may not always be an appropriate educational tool, especially for centers with large populations of low literacy clients like Honolulu's KKVHC. Audiovisual mechanisms, such as health education videos, posters, and the use of community media channels, such as radio and television, may be more effective vehicles for reaching these populations.

Health education interventions. The use of translated health education materials is only one aspect of health education. Program interventions for smoking cessation, HIV prevention and other health areas must also be linguistically accessible and culturally appropriate. The health center sites have developed health education programs which incorporate the various languages and cultures through the use of multilingual/multicultural community health workers to implement the interventions.

Translated Signs and Information. In addition to educational materials, most sites use translated signs and information within their facilities. The primary type and location of signs used include:

- ☛ No smoking signs
- ☛ Identification of offices, departments, and rest rooms
- ☛ Health center hours and holidays
- ☛ Instructions for patients (such as where to put laboratory specimens, "point to the language you speak")
- ☛ Consumer rights
- ☛ Health center fees and policies
- ☛ Emergency and safety information

Two sites do not use signs in Asian or Pacific Islander languages. Los Angeles' AHP, located in THE clinic, serves a significant number of African American and Latino patients; the majority of signs at this site are in English and Spanish. Honolulu's KKVHC uses few signs

in any language (including English) because their facility is small (4,000 sq. ft.) and because the majority of their patients are low literacy.

Written Translation. The need for health education materials, forms, and other information in API languages has resulted in the development of internal systems for written translations in all but one AAPCHO center.

The number of staff involved in written translations per site ranges from four to 25. The sites that have greater numbers of people doing translations tend to translate into more languages. Although the process used by each site may vary slightly, the translation process can include development, cultural/community adaptation, direct translation, proofreading, pretesting, back translation, revisions, and final editing. As these findings indicate, translations represent a significant investment in staff resources.

Materials have been developed in more than ten different API languages, including Chinese, Japanese, Khmer, Korean, Lao, Samoan, Tagalog, Thai, Tongan, and Vietnamese. Although most written translations are done by staff members, some sites rely on outside support or consultants. Staff involved in translation and production of materials have written language skills, knowledge of the subject matter, ability to write at the appropriate literacy level, and knowledge of how to present information in a culturally appropriate manner.

Clinic Forms and Information. Written forms and information are another important part of providing linguistically accessible services. They are used to supplement and complement verbal communication. Translated registration forms help facilitate the completion of forms by patients who are literate in their primary language. Instruction pamphlets ensure that patients understand and are able to follow instructions related to required treatment or follow-up visits. Translated informed consent forms and other information are considered essential in ensuring that the patients' rights are protected. Translated referral information is provided to assist patients in successfully accessing the services to which they are referred. The sites also provide translated let-

C

ASE STUDY 4:

Mr. N, Vietnamese

Mr. N, a 26 year old man, recently arrived in the United States, from Vietnam with his wife and two year old son. One evening, he arrived at the emergency room carrying his son, gesturing that his son needed medical attention because he has had a fever and a cough for the past two days. A nurse took the son to an examination room, where she noticed bruising over the sternum and along the spine. She summoned the physician, and though the bruised areas did not appear tender, they suspected child abuse. Mr. N was questioned by the physician; however, because Mr. N speaks very poor English, communication was difficult and frustrating for both. Finally, a young Vietnamese woman from housekeeping was recruited to help interpret. After a short discussion with Mr. N, the young woman explained the custom of "coin rubbing" to the emergency room staff. On further examination, the physician could find no other evidence of child abuse. The son was given an injection of antibiotic and discharged.

ters to patients, clinic-related forms, and billing information. Most of these translated materials are developed by the health centers because they are not available elsewhere.

Cultural Competence

In addition to being linguistically accessible, the AAPCHO health centers' services are striving toward providing culturally competent services[†]. They incorporate cultural knowledge into their clinical practice, health education, and general health center practices. This requires a broad knowledge of cultural beliefs and practices, including dietary practices, health care beliefs and practices, and family decision-making structures for each cultural group served. Further, Western medical practices and procedures are introduced to patients in a way that can be understood within their cultural framework.

The health centers emphasize respect for cultural practices and beliefs, which involves reinforcing and promoting aspects of culture that contribute to positive health.

The health centers also emphasize respect for individuals, and his or her own belief system. Therefore, the health centers must assess the needs of each individual without making assumptions based solely on their cultural origins.

Examples of cultural competency in a health care setting include a) acknowledging traditional dietary practices, b) understanding cultural beliefs related to health and health care, c) understanding cultural decision-making structures, and d) incorporating cultural knowledge into health practices.

Acknowledging Traditional Dietary Practices. The health center staff are aware of the dietary practices of the cultural groups they serve, and they integrate this awareness into clinical practice, health education, and nutritional counseling. For example, Chinese congee is a popular rice porridge that is traditionally served at home. Pediatricians are aware that immigrant Chinese mothers feed congee to their infants. The pediatricians take this into account when counseling mothers about switching their infants to solid foods; doctors also prescribe it when a child has diarrhea.

Understanding Cultural Beliefs Related to Health and Health Care. The health centers must address existing cultural beliefs in a careful and sensitive manner. For example, some Asians believe that blood is sacred and that there is a finite amount that cannot be replaced. Consequently, decreasing the amount of blood (for example, through blood drawing) weakens the body. Staff must be sensitive to this belief in explaining why blood tests are necessary and in reassuring patients that the body replenishes its blood supply.

Understanding Cultural Decision-Making Structures. Traditional decision-making structures also influence the delivery of health education and health care. For example, in many traditional Chinese families, married couples live with the husband's parents. The mother-in-law usually is consulted when issues concerning her daughter-in-law arise. At San Francisco's NEMS, an

[†] The term *cultural competence* is used to emphasize that meeting the needs of culturally diverse populations involves competence. The term is used to refer to entire systems and organizations of care as well as the individuals within those systems. It has a broader meaning than cultural sensitivity, which is only one aspect of cultural competence.

expectant mother is usually accompanied by her mother-in-law, who may refuse to allow amniocentesis and other procedures. The nurses and staff work closely with the patient and her mother-in-law to ensure that they are both adequately informed and involved in the decision-making process.

Incorporating Cultural Knowledge into Health Center Practices. Since seeing a doctor on the first day of the new year is frowned upon by some Asian cultures who believe that it could lead to health problems for the entire year, several AAPCHO health center sites close their doors on the Lunar New Year.[†] During this time, health center educators are careful to focus their programs on health enhancing themes such as nutrition and avoid the mention of illness, disease, and death. It is clear that cultural considerations are at the core of a wide range of health center activities. The health center sites have developed a high level of cultural knowledge that is integrated into their practice in many different ways.

Providing a detailed description of cultural competency is not within the primary scope of this report. Several other journal articles^{1,2} have described cultural barriers to health care for APIs in more depth.

Staff Composition and Required Skills

Combined bilingual and multilingual staff members make up the majority of staff members at all health center sites. The percentage of bilingual individuals within the total staff ranges from 15 to 47 percent at the AAPCHO centers, and the percentage of multilingual staff members ranges from 33 to 78 percent. Among direct services staff (i.e., those who spend more than 10 percent of their time in direct contact with patients), the proportions of bilingual and multilingual staff are even higher.

Providing culturally and linguistically appropriate health care services, like any other job, requires special skills. The health centers identified the following skills and knowledge necessary for providing linguistically and culturally appropriate services to APIs:

Cultural knowledge. Providers and interpreters should have knowledge of cultural beliefs and practices, including dietary patterns, traditional healing practices and beliefs, and cultural decision-making structures. They should also have the ability to integrate this knowledge into service delivery, for example, by informing a patient of a serious and potentially terminal diagnosis in a culturally-appropriate manner.

Cultural interpretation. Whether or not an interpreter is used, the health center sites reported that communication involves "cultural interpretation." In contrast to literal translation, cultural interpretation is a method of interpreting ideas or concepts across cultures. Thus, providers and interpreters must be able to interpret Western biomedical concepts in the cultural framework of the patient and respond appropriately to patients' questions and concerns.

Language skills. Interpreters and providers who communicate directly with patients in API languages must be both fluent in English and in the patient's primary language. They also must be familiar with formal and colloquial terms in the patient's language and be able to communicate with individuals of different socioeconomic and educational backgrounds.

Medical terminology and concepts. Interpreters must be familiar with basic anatomical and medical terminology and concepts (both technical and nontechnical). Providers working with interpreters must be able to communicate in a manner that can be understood by the patient.

Patient rights. Providers and interpreters must be familiar with patient rights. In particular, they must adhere to the right to confidentiality. In smaller API communities, where many people are related to or know each other, reassuring patients of confidentiality takes on greater importance than in larger communities.

Roles and responsibilities of providers and interpreters. Providers and interpreters must have an understanding of how to work as a team to establish positive communication with patients. This may involve a brief review of concerns prior to the patient encounter to ensure that interpretation needs are fully understood. A debriefing

[†] Lunar New Year is known most widely as Chinese New Year in the United States. However, it is also celebrated as Tet in Vietnam and in the Vietnamese community in the United States.

following the patient encounter will allow the provider and interpreter to compare observations, decide what's best for the situation and discuss any follow-up required. The interpreter may pick up subtle, but important, verbal and nonverbal cues that may be missed by the provider. Through training, providers and interpreters should also be aware of various models and modes (e.g. consecutive, summary, simultaneous) of interpretation.

Patient-provider-interpreter dynamics. Providers and interpreters must understand and be sensitive to the dynamics involving patients, providers, and interpreters. An emphasis must be placed on communication with the patient as opposed to between the provider and interpreter. Common errors, such as providers speaking to the interpreter instead of the patient, should be avoided. Some health centers reported that seats are arranged so that the primary visual contact is between the patient and provider. In situations involving discussion of sensitive topics such as sexuality or mental health problems, special attention should be paid to such dynamics. The role of both provider and interpreter should be explained to patients to promote effective participation in this three way communication.

Recruitment

The nine health center sites' recruitment practices are very similar and a variety of methods are used to attract and hire new personnel. Assessments of staffing needs are conducted periodically. Health centers take immediate action to get vacant positions filled to minimize disruptions in clinic services.

For purposes of this report, the staff of the health center sites are categorized as follows:

Medical doctors. Includes internists, pediatricians, obstetricians/gynecologists, general practitioners, family practitioners, specialists, medical interns, and residents.

Other clinicians. Includes nurse practitioners, physician's assistants, psychologists, hygienists, dentists, orthodontists, optometrists, podiatrists, clinical social workers and acupuncturists.

Other clinical staff. Includes nurses, pharmacists, medical assistants, midwives, physical therapists, and various technicians.

Other direct service providers. Includes health educators, social workers, nutritionists, eligibility workers, counselors, community health workers, teachers and aides.

Support service staff. Includes non-clinical support staff with direct patient contact such as medical interpreters, clinic receptionists, appointment/intake workers, medical records clerks and cashiers.

Administrative staff. Includes executive directors, associate directors, fiscal directors, chief accountants, managers, administrators, project coordinators, development staff, management information systems analysts, human resource officers, and administrative assistants.

Recruitment Strategies

The following are common approaches used by the health centers to promote and hire staff:

1. Networking and posting job vacancies with medical, nursing and public health schools, community health centers, professional and alumni associations, and in the business community.
2. Advertising through mainstream media, local API community newspapers and magazines, professional journals and periodicals.
3. Obtaining referrals from community-based organizations and community leaders;
4. Promoting staff who earn advanced skills and degrees while providing for educational benefits to develop staff.
5. Networking with interns and residents who receive clinical training at the health centers through center-sponsored programs.
6. Cultivating relationships with future candidates who are not immediately available.
7. Hiring competent and reliable volunteers.

Honolulu's KKVHC recruits heavily among foreign-trained health professionals, who are not licensed to practice medicine in the United States. These individuals are highly qualified to provide nonreimbursed medical support for which no license is required. With their com-

bined training and language/cultural skills, these health care professionals have great potential to serve the health center's patient populations.

Language Needs and Priorities

All of the health center sites give priority to hiring clinicians with the appropriate training, commitment, sensitivity, and skills. Hiring individuals with cultural knowledge and fluency in any of the major languages of the population is also a priority. At Honolulu's KKVHC, a preference for hiring local residents and multilingual individuals is board mandated.

Because of the shortage of health professionals who are multilingual or multicultural, hiring clinicians who meet these requirements is a major challenge. Some of the sites remain steadfast in their determination to hire staff with these skills and will leave positions vacant until such individuals can be recruited.

However, some sites hire individuals with appropriate clinical skills, credentials, and sensitivity, even if they do not possess the desired language skills. In these situations, language needs are met through interpreters.

When initiating services for a new language community, Oakland's AHS has a policy of hiring at least two staff members (usually one in support services and one in health education) who speak the given language. This ensures back-up language coverage, for example when a staff member is on leave.

Obstacles to Recruitment

Despite concerted recruitment efforts, common barriers exist in finding qualified multilingual and multicultural personnel that meet staffing requirements. This is particularly challenging in filling vacant clinical provider positions.

Recruiting and hiring multilingual and multicultural staff requires a much greater investment in resources than hiring monolingual (English-speaking) providers. Other difficulties include the lack of primary care providers and inability to offer competitive salaries.

Clinicians. The pool of primary care clinicians, especially those with multilingual/multicultural skills, is very small; this is particularly true for more recently-arrived API groups such as Laotians and Cambodians. Many APIs in health professions training choose to enter specialties other than primary care. Others are not licensed to practice in the United States. Furthermore, health centers, especially those in high-cost areas, have difficulty competing with the higher salaries offered in the private sector.

Other clinical staff and direct service providers.

Barriers for this group are similar to those for clinicians. There is a small pool of nurses and medical assistants who are multilingual/multicultural. Those who have the language skills may lack the licensure to practice in the United States. Competition for these individuals is fierce, and health centers have difficulty competing for the reasons mentioned above.

Service providers and line staff. The health centers also state that the pool of multilingual and multicultural health educators and other service providers is very small. Although there are many individuals who have some of the skills required, it is difficult to find people who possess the appropriate mix of experience and job skills, including oral and written language skills and cultural interpretation skills. Health centers often train individuals who have language skills in other job-related skills. Individuals with these skills are in high demand and, as a result, are difficult to recruit.

Administrative. There are limited development and training opportunities at universities to provide a pool of individuals with skills related to health center administration. It is important to screen potential staff for their level of cultural knowledge and sensitivity.

Geography may play an important role in ability to recruit staff. For example, a larger supply of multilingual/multicultural health workers exists on the West Coast than on the East Coast. The difficulties in recruiting staff are more pronounced for the East Coast health centers.

Training

Training in the nine health center sites historically has been conducted on an informal basis. The approaches used most often to transmit staff knowledge, techniques, standards, and procedures are workshops, classes, on-the-job training, cross cultural training and in-service training.

The ability of staff to learn the skills and knowledge required to provide linguistically and culturally appropriate services without the benefit of formal training programs is a strength of the health centers. However, only a few sites have training materials to enhance their in-service and job instructions. Some health center sites are moving in this direction, but their efforts depend on grants and funds to supplement their strained budgets.

At the health center sites, staff work closely with newer staff to ensure the transfer of skills related to providing linguistically and culturally appropriate services. Despite its success, this approach to training requires an inordinate amount of time and resources when a new employee is hired.

Training Methods and Content

The health center sites cited a number of training approaches.

Clinicians. Two training approaches were identified: (1) A 2-week pediatric internship to orient staff to a bilingual and bicultural community health center setting (Boston's SCCHC), and (2) a training program taught to clinicians by a professional trainer from the Monterey Language Institute on how to work with interpreters (Oakland's AHS).

Service providers (including interpreters). Several training and educational aids included: (1) Interpreter workshops; (2) an 8- to 10-session course on basic medical terminology and interpretation techniques and standards; (3) two videoape series on interpreter and cross-cultural training; and (4) cassette tapes on medical terminology in Chinese.

Training from a cultural perspective can help new interpreters better understand medical terminology and procedures when working with providers and patients. For example, patients' cultural expressions of pain and suffering were identified first and then these expressions were connected to U.S. mental health terminology and concepts.

At Oakland's AHS, the training provided to clinical staff and interpreters by the Monterey Language Institute emphasized a team approach. Providers and interpreters were encouraged to establish partnerships, rather than "top-down" relationships. Providers were encouraged to explain methods, procedures, and medical terminology to an interpreter and describe the ideal clinical encounter. While working together in the examination room, the interpreter learns skills in explaining the symptoms of the patients. This builds the interpreter's confidence in giving observations and feedback to the providers. The Institute encouraged pre-visit and post-visit discussions between provider and interpreter.

AHS also provides cultural sensitivity training for the staff whenever a new community is being served. In addition, the center periodically repeats cultural sensitivity trainings on each ethnic group served.

The health center sites' ability to recruit, train and retain multilingual/multicultural staff is a key factor in their success at providing linguistically and culturally appropriate services. To ensure that staff have the appropriate skills and knowledge, the centers also must place a strong emphasis on staff training and development.

While it is important to place much focus on recruiting and training staff, staff retention is equally important. With the number of qualified multilingual staff limited, competition from larger health organizations eager to hire away staff poses a very real threat.

Other Related Health Center Services

Beyond providing services from their own facilities, the health centers act as advocates to ensure that API communities receive adequate

care from the entire health care delivery system. They also serve as a link to other social and human services needed by their patients.

Patient Advocacy

Individual patient assistance/advocacy. Health center staff provide a link to services outside of primary care. Case management and advocacy unrelated to primary care may not be staff duties, but patients will turn to staff for help on advocacy issues that are related to ESL (English as a Second Language) programs, vocational job training, social security, immigration, court, and dealing with local government.

Informing patients of their rights. The health center sites actively inform patients of the right to receive health care services in their own languages. The most common method of informing patients is verbal. Several health center sites also use written means and translated signs. Two health centers use API-language radio and newspapers to inform patients of their rights (Los Angeles' APHCV and San Francisco's NEMS).

The health centers also use educational forums to inform patients about changes in health care that will affect them. For example, Oakland's AHS conducts an annual general membership meeting attended by 300-400 patients. The meetings are conducted in nine different languages. Because their patients have limited access to media information about changes in health care and patient rights, the health center assumes the responsibility of providing them with this information. Boston's SCCHC also shoulders the responsibility for educating their patients and the broader Asian community about the changes in health care, such as the transition to managed care in Massachusetts. When translated informational materials on managed care were not available, the health center assumed responsibility for translating these materials.

Advocacy to impact systems/policies. All of the health centers play an active role in advocating for improved accessibility for the communities they serve. For example, CHC as an advocate for multilingual and multicultural health care services in New York City protested the firing of bilingual workers at a local hospital because of funding cut-

backs. Boston's SCCHC has worked to improve language access within the social services agency that conducts Medicaid eligibility screening.

Referrals

The health center sites made referrals to county, city, and private hospitals for immunology, radiology (including mammography), advanced lab tests, emergency services, urgent and acute care, labor and delivery, other obstetrics/gynecology services, serious illness, and surgery. Patients are referred to private providers for optometry, ophthalmology, dentistry, and other specialty care.

All health center sites assist their patients in obtaining language access to the referred services. For example, staff members frequently assist patients in making appointments with other service agencies. In addition, they address language access for their patients in the following ways:

- ☞ by providing an interpreter;
- ☞ by referring to an agency that provides interpreters or has bilingual staff;
- ☞ by arranging for an interpreter;
- ☞ by requesting that the referred agency provides an interpreter.

According to a majority of the sites, patients must sometimes rely on family members or friends for interpretation because of the lack of translation services at the referred agencies. For example, the hospitals utilized by New York's CHC patients do not guarantee interpreter services for limited-English-speaking patients. As a general rule, all CHC patients referred to outside medical services are instructed to bring their own interpreters. In contrast, Seattle's IDCHC provides an interpreter at all times. The ability to do this can be attributed to the existence of a language bank that provides interpreter services to local agencies.

Providing Outside Interpretation Services

Staff and volunteers from the health centers frequently accompany patients to other providers and offer over-the-phone interpretation. Staff at four health center sites (Boston's SCCHC, Oakland's AHS, Seattle's IDCHC, and

Honolulu's KKVHC) assist patients in finding additional services outside the clinic and routinely accompany patients to other agencies.

SCCHC staff accompany patients most frequently, that is, an estimated 100 to 115 times per month. The majority of patients escorted by staff are from the obstetrics/gynecology department. SCCHC also provides interpretation between hospitalized patients and hospital staff in medication consultation.

AHS staff accompany patients approximately 20 times per month, although there are many more requests than AHS staff can meet. About one-third are HIV-related cases; the remaining two-thirds are mothers in delivery accompanied by bilingual labor coaches. AHS also responds to requests from a local hospital to interpret for genetic counselors and from county health care services and social security for intake interpretation. Over-the-phone interpretation is provided to the Department of Social Services for Medicaid applications and to a local hospital.

IDCHC bilingual and multilingual family health workers accompany patients 13 times per month, while KKVHC staff accompany patients 2.5 times per month. The other five health center sites accompanied patients much fewer times each month.

In the past, San Francisco's NEMS staff routinely accompanied monolingual patients to the Department of Social Services (DSS) and other agencies. However, due to limited number of both NEMS staff and Chinese-speaking DSS staff, this is now an infrequent occurrence. New York's CHC and Los Angeles' AHP/THE accompany patients approximately bi-monthly.

Two Los Angeles health center sites stated that they have not accompanied patients. CSC which mentioned liability as a concern refers patients to other Chinese-speaking providers but does offer some over-the-phone interpretation. KHF occasionally provides over-the-phone interpretation and writes letters or makes phone calls on behalf of patients when making referrals.

The majority of health center sites have no formal agreements with other agencies for which they provided interpretation services. Boston's

SCCHC receives an hourly fee for services provided to the Department of Mental Health without a formal agreement. An exception is CHC, which has formal agreements with a hospital and another health center in New York City. These agreements outline collaborative relationships and provide compensation to CHC for their assistance in serving the Chinese community. CHC believes such agreements are beneficial in increasing access to services and in ensuring communication and accountability between the organizations involved.

Other Assistance Provided

The health center sites identified additional services they provide to other agencies and associated costs. The following areas were identified:

Translation of materials. The health center sites sometimes initiate the translation of materials to increase access to information the community needs. SCCHC in Boston used this approach following the implementation of managed care. In other cases, the health center sites regularly receive requests from other agencies to perform translation.

Providing health education services. The health center sites often receive requests for health education services, such as classes and educational services for patients served by public and private hospitals.

Providing case management and support services. Oakland's AHS provides HIV case management services although initial funding was for education only. This program has grown in response to requests from several agencies that lacked the language capacities to meet patients' needs. Boston's SCCHC also responds to requests from the Department of Mental Health to provide psychiatric evaluations for Asian patients.

Providing noncovered services for insured patients. The health center sites provide services to insured patients who cannot afford deductibles and to Medicaid patients who receive services elsewhere but come to the centers for services not reimbursed by Medicaid.

Providing services for patients enrolled in Health Maintenance Organizations (HMOs). Some patients who are enrolled in HMOs prefer to seek the services of the health centers because of the language capacities of the staff.

Providing educational services, including cross-cultural training, for other agencies. The health center sites provide education on request to other agencies on the social services needs and cultural practices of the populations being served.

Training Health Professionals. All of the health centers have linkages with local health professions institutions. Through these linkages, the centers provide community-oriented primary care opportunities, including rotations for health care professionals, students and residents interested in working in primary care settings. This allows providers who are educated in the United States to gain experience working with limited-English-speaking patients from a variety of cultural backgrounds. Training in the health centers also orients clinicians to clinical issues that affect API communities, to culturally competent approaches of serving specific populations and to the community health center model.

These are only a few examples of the indispensable role played by API-focused health centers within the greater health care system. The beneficiaries of their assistance are not only the patients, but other health and social service organizations and aspiring health professionals and paraprofessionals.

Evaluation Methods

Most of the health center sites incorporate evaluation of language access into their overall program evaluation. Patient feedback concerning language access and cultural competence is sought through a variety of methods, including patient satisfaction surveys, general patient meetings, patient access to staff and board members and suggestion boxes.

Staff also provide input into the program evaluation process through quality assurance committees, patient care assessments, departmental meetings, management meetings and review of written translated materials.

The boards of directors, which have strong consumer involvement, participate in the evaluation of programs and services. Boston's SCCHC holds an annual board retreat to discuss the previous year and make plans for the upcoming year. Each department at San Francisco's NEMS reports to the board on an annual basis; at that time, the board discusses the department's progress and goals for the upcoming year. Los Angeles' APHCV, as an umbrella agency, is responsible for quality assurance at its member sites (AHP/THE, CSC, and KHF). Site reviews are conducted by funding sources including state and federal government agencies.

In addition to program evaluation, individual staff members are evaluated. Staff who use their language skills are evaluated for those skills as well as skills related to specific job responsibilities (San Francisco's NEMS). Cultural competence of staff members is also evaluated during the initial job interview (NEMS and New York's CHC) or by peer observation (Los Angeles' AHP/THE).

Some of the health centers are in the process of developing more formal evaluation mechanisms for language access and cultural competence. Oakland's AHS has worked with Berlitz to design a tool to assess quality of interpretation. This tool involves evaluating audio recordings of the interpreters. APHCV has indicated that results from the Language Access Project will be used to assist in designing an evaluation tool.

References:

¹ Uba L. "Cultural Barriers to Health Care for Southeast Asian Refugees." In *Public Health Reports*, Vol.107, No.5, Sept-Oct 1992, pp. 544-548.

² Hoang GN and R. Erickson. "Cultural Barriers to Effective Medical Care Among Indochinese Patients." In *Ann. Rev. Med.*, 36, 1985, pp. 229-239.

CHAPTER III: Financial Issues Related to Language Access

One of the Language Access Project's aims was to describe some costs incurred by the health centers as a result of providing linguistically accessible services. These costs include, but are not limited to, interpreter costs, recruitment and training of multilingual/multicultural staff, and other costs related to language access. The information presented in this section constitute a preliminary attempt to identify and describe costs associated with language access.

The Language Access Project conducted a study to measure the difference in costs between an encounter that involved an interpreter and one that did not require an interpreter. (Results from this cost study are listed in the **Appendix C**.) Generally, the study found that for most time interval periods, encounters requiring interpreters took more time and cost more than ones that did not require interpreters. However, cost analyses of interpretation services in a diverse clinical setting are complex, and additional studies are needed to further examine this issue.

The health centers provided information on costs related to recruitment, training, evaluation, and other related language access functions.

Recruitment

Although data on recruitment costs were limited, health center information seemed to suggest that recruitment costs for centers hiring multilingual/multicultural staff were higher than for centers needing only monolingual-English or bilingual/bicultural staff. These higher costs related to the small pool of qualified candidates and competition with other health centers. Health centers identified various recruitment expenses (advertisements, postage, duplication, staff time), but these costs were not tracked separately. Comparing these costs with the costs of recruiting English-speaking staff was beyond the scope of this project.

A very significant cost related to recruitment was staff time for recruiting. Searches to hire competent, linguistically skilled staff that met health center standards were lengthy and frequent. Recruitment involved producing and distributing job announcements, contacting var-

ious organizations and networks, reviewing applications, interviewing applicants, conducting phone follow-ups and writing letters.

Advertising for these positions was also very costly. For example, New York's CHC spent \$3,200 on newspaper and medical journal advertisements in 1992 to recruit physicians; its costs for advertisements in local ethnic newspapers ranged from \$120 to \$250 per week per newspaper. Boston's SCCHC spent \$6,000 on advertising job openings in 1992.

Another recruitment-related cost incurred by the health center sites is the impact of vacant provider positions which can result in a loss of productivity and revenue. Over a long period of time, such vacancies also produce lengthy waiting lists and increases in waiting time for appointments. It can also have a larger impact on program development, perhaps even postponing the implementation of some programs.

At New York's CHC, the medical director provided pediatric services for an entire year while the agency tried to fill a vacancy in the bilingual Chinese pediatrician position. This affected her ability to carry out her medical director duties. The health center sites often are willing to make such sacrifices to maintain their strong commitment to hiring bilingual or multilingual staff. The costs related to recruitment and prolonged provider vacancies constitute hidden costs that must be absorbed by the health center sites.

Training

The health center sites incurred extra training costs because of the need for specialized language and cultural skills. Most health center sites did not have cost figures on this type of training, and staff time related to training is not tracked separately. However, Oakland's AHS piloted a 12-hour interpretation training program at a cost of approximately \$24,650 for 20 students.

In most situations, training is conducted informally and relies heavily on on-the-job training methods. Other examples include multi-media demonstrations using video and audio cassettes,

workshops, and cultural sharing during weekly staff meetings. Most costs related to training were absorbed by the health centers.

Evaluation

Health centers do not track evaluation costs separately, because evaluation of language access and cultural competence is integrated into overall program evaluation.

Consumer Involvement

Providing multiple language interpretation for consumers requires additional effort because of the added complexity and cost for extra languages. Oakland's AHS estimated the costs for planning and conducting annual general membership meetings to be approximately \$35,000 per year. This cost includes staff time for planning, conducting outreach to patients, and providing interpretation at these meetings. In 1994, AHS researched the purchase of equipment for simultaneous interpretation and found it would cost approximately \$14,000.

descriptions do not require bilingual qualifications. Boston's SCCHC does not have a policy for pay differentials but will negotiate higher salaries or other benefits for highly qualified multilingual providers.

Interpreter Costs

Oakland's AHS budgeted for four to five full-time staff interpreter positions in 1992. However, this did not include the costs for all other staff members who assisted in interpretation as a part of their job functions. Seattle's IDCHC has an annual budget of \$1000 for outside interpretation.

Revenues

The participating health center sites reported that their revenues are derived primarily from grants, contracts, third-party reimbursements, and patient revenues. Grants and contracts come from local, state and federal government agencies and, to a lesser extent, private foundations and corporations. Third-party reimburse-

Although the health center sites incurred costs related to providing linguistically and culturally accessible services, funding specifically for this purpose is almost nonexistent.

Other costs associated with consumer involvement include staff time for organizing and interpreting at meetings (e.g., advisory committee meetings or general membership meetings at which services are evaluated) and written translation of patient satisfaction surveys.

Pay Differential

Two health center sites reported a pay differential for language-skilled staff. Oakland's AHS pays an annual bilingual premium of \$600 per full-time-equivalent if the staff person uses their Asian language skills at least 10 percent of the time. Seattle's IDCHC pays a 2.5 percent differential for bilingual staff whose job

ments come from Medicaid, Medicare, and other government insurance programs as well as some private insurers. Uninsured patients constitute a large proportion of health center patients (on average, about 65 percent); these individuals are charged for services on a sliding-fee scale. Records indicate that patient fees usually constitute a small percentage of the health centers' total revenue.

Although the health center sites incurred costs related to providing linguistically and culturally accessible services, funding specifically for this purpose is almost nonexistent. Oakland's AHS, San Francisco's NEMS, and Boston's SCCHC receive some grant funds to cover a small portion of their language access activities.

However, activities funded by grants (e.g., training, staff-interpretation) were only on a one-time basis and forced health centers to seek additional funds for maintaining multilingual staff and language access activities.

Until recently, cost-based reimbursement programs, such as Medicare and Medicaid, provided some support for additional language-related functions. Costs that are directly related to clinical encounters can be included in cost-based reimbursement under these programs; however, other language access expenses are not covered via this mechanism. These programs also fail to cover the majority of health center patients who do not receive Medicare or Medicaid benefits.

CHAPTER IV: Impact of Managed Care Environment on Language Access

The Language Access Project was conducted in 1993, before managed care began to impact the discussion on language access for the API community. Although managed care has been implemented to different degrees in geographic regions, there are some serious concerns on how it will impact language access in the health care services environment. The following discussion, based on a few recent reports and key informant interviews, will provide some insight into the analysis.

Limitations

1. *Unpredictability of managed care environment.* In this updated section on managed care environment's impact on language access, the discussion and recommendations were developed based upon information reviewed at the time of writing this report (mid-1996). The fluidity of the managed care scene may impact the standards, guidelines and recommendations specifically, although the general concepts are likely to remain the same.

2. *Brief overview.* This section is intended to present a preliminary overview of some of the managed care issues and not meant to be an exhaustive discussion of managed care's impact on language access. The complexity and fluidity of managed care by state and by region will change the focus of the relevant discussion with regards to language access.

Key issues

There are several federal and state laws that require health care providers to offer at minimum, adequate translation services for limited-English proficient (LEP) patients.¹ These laws, regulations and standards were designed to protect a patient's right to receive linguistically accessible health care and include the following: Title VI of Civil Rights Act of 1964, Hill-Burton, Medicaid regulations, and the Disadvantaged Minority Health Care Improvement Act, state regulations like the State of California, and other standards developed by organizations like the Joint Commission on Accreditation of Healthcare Organizations.

Some of the key issues related to managed care include the following:

1. The complexity of the managed care enrollment process for Medicaid-eligible consumers will likely create additional barriers for linguistically isolated clients. This may result in the assignment of a "default" primary care provider who may not be able to provide the necessary linguistically and culturally appropriate services. In some areas, consumers will get a choice of health care plan and provider during the enrollment process. Already, there is much confusion over the enrollment process, the deadlines and the options for health plans. When language access to information about the enrollment process is poor or nonexistent, tremendous barriers are created for the limited-English speaking API communities. As a result, those consumers who do not "enroll" will be automatically assigned by "default" to a health care plan and provider who might not be the best choice in providing them with linguistically accessible services.

This provider will be the patient's sole gatekeeper to health care. An important question is whether the gatekeeper has the ability to assure language access. In this new "closed" system, the patient may not have a chance to make changes in providers after the enrollment process. If the provider doesn't address language needs, the limited-English speaking patient will not be able to access the system.

Already, "horror stories" have described the failure of the enrollment process in some areas. In California, some areas have estimated that 65 to 75 percent of the eligible patient population has not enrolled, resulting in their "default" assignment to a provider. This is particularly significant for those areas where up to 25 percent of the managed care patient population is limited-English speaking.

2. Reimbursement for language services is extremely low or nonexistent. As health centers negotiate for an adequate capitation for comprehensive primary health care services, it will be important to advocate for reimbursement of language services. However, due to the difficulty of isolating the costs for language services and convincing policymakers and payors of the

importance of language, capitated rates for language services will be extremely low at best. For example, the portion of the current capitated rate allocated for "enabling services" which includes translation, transportation and others in Alameda County, California has been estimated as only \$0.03 per member per month.

4. Currently, many managed care plans do not have staff with appropriate language and cultural competency skills. Many of the health care facilities that are trying to expand their services into the API community do not necessarily have the staffing and resources to provide full linguistically accessible and culturally competent

Under managed care, there needs to be standards established and enforced for plans and care providers who enroll limited-English speakers.

A survey of 10 states² revealed a lack of uniform standards and guidelines for ensuring language appropriate health care. A key element in ensuring appropriate access has been the funding and compensation allocated for interpreter services. In a 1995 National Public Health and Hospital Institute survey, most hospitals used general funds and almost no federal, state or local grants to pay for interpreter services.

While some states, like Minnesota and Washington, provided the most progressive reimbursement approaches for interpreter services, most of the surveyed states had inadequate provisions for reimbursing language interpretation. This inadequacy and the states' variability underscores the importance of closely monitoring the manner in which health plans are reimbursed for providing linguistically accessible health services.

3. The California State Department of Health Services' Request for Applications outlined specific cultural and linguistic service requirements of the Medi-Cal managed care program. In these contractual requirements, they have specified what population groups require linguistic services by defining Medi-Cal eligibles who have a primary language other than English and who meet a numeric "threshold" of 3,000 or meet the concentration standards of 1,000 in a single zip code (or 1,500 in two contiguous zip codes). This new definition of "threshold" has meant that many more Asian language groups are covered than before.

services. Although they may have translated health education materials available in one or more API languages, this by no means assures that language access is provided.

5. The focus of managed care on cost efficiency may provide a disincentive for the health center to invest in supplemental services for clients facing language and cultural barriers. Cost restraints and low capitated rates will also impact the ability of community health centers to provide supplemental services.

6. The National Committee for Quality Assurance, a nonprofit organization founded to assess the quality of managed care plans, designed the Health Plan Employer Data and Information Set (HEDIS) to evaluate and measure the performance standards for health plans. A proposed and evolving HEDIS 3.0 Measure on Language Appropriateness Measure would define and describe language appropriateness standards that apply to all covered populations (Medicare, Medicaid, commercial). It would propose to measure whether health plan members felt that they are being communicated to effectively in their primary language.

7. The competitive nature of the managed care environment will test the ability of health centers to continue to provide language access for limited-English speaking API populations. On one hand, the managed care environment will force health centers to expand their patient population in order to compete with larger health care organizations. This may mean expanding services of AAPCHO health centers

to other communities besides APIs. Health centers will no longer be able to just focus on a low-income, limited-English speaking, high-user, predominantly immigrant population because the new market-driven system will not subsidize this population. There will be a need to have users with private insurance as part of the patient mix. Under managed care, a capitated rate tends to benefit those health centers who have healthier patients (that require less frequent and shorter medical visits).

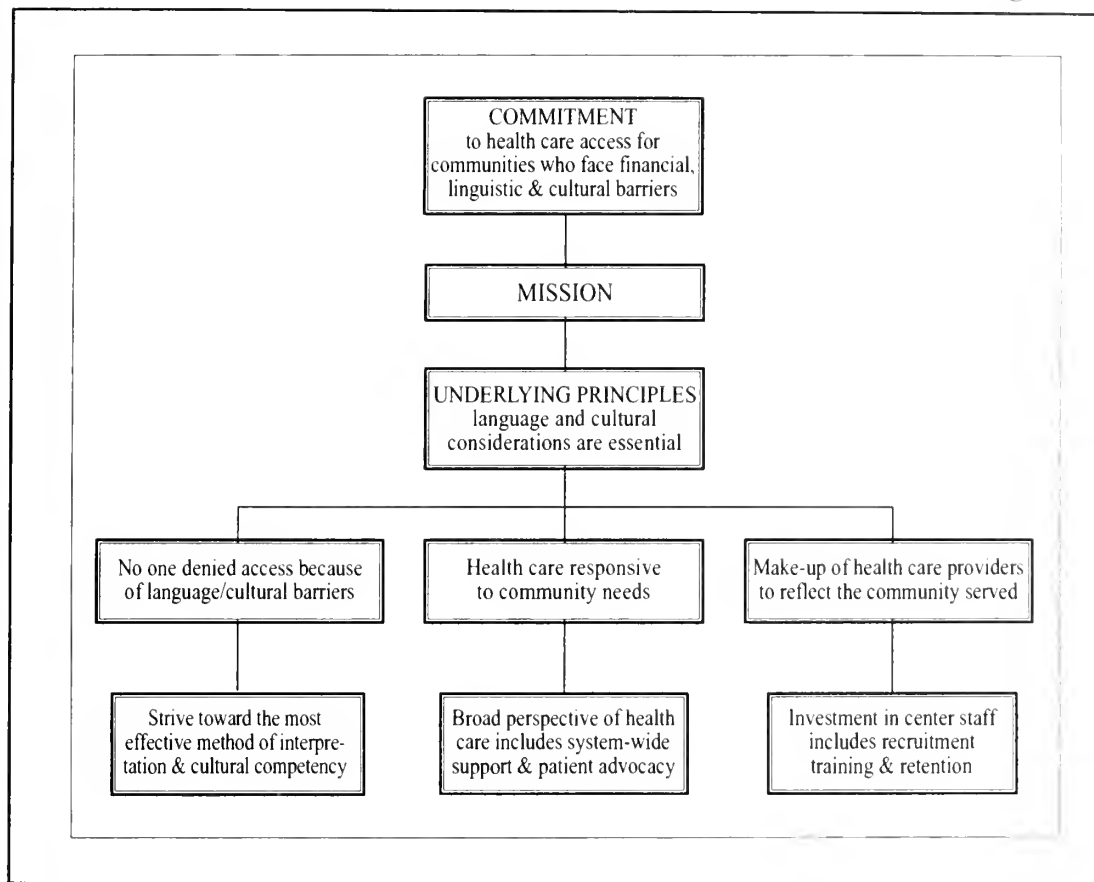
8. In response to inadequate language access, a few language access programs serving APIs have been developed. Oakland's Asian Health Services started the Language Cooperative to provide a convenient and cost-competitive resource for specialized language assistance in the health care field.

References

1. Perkins J and Vera Y. *Legal Protections to Ensure Linguistically Appropriate Health Care*. September 1995.
2. Association of Asian Pacific Community Health Organizations. "State Medicaid Managed Care: Requirements for Linguistically Appropriate Health Care". Oakland, California. January, 1996.

CHAPTER V: MODELS, STANDARDS, GUIDELINES, AND RECOMMENDATIONS

Figure 14



Currently, the debate over future directions for health care delivery in the United States is reaching new heights. A central issue is how health care access will be improved for underserved populations. Certainly, API communities that face language, cultural, and economic barriers to health care are among those who have been historically shut out of the health care system.

The nine AAPCHO health center sites serve as models in providing access to health care for underserved communities. Yet, the very future of these community-based health care providers may be threatened by current proposals to transition the delivery of health care into large managed care systems. Therefore, in redefining and reshaping the nation's health care system, it is crucial that those community-based models that enhance access to health care be preserved and promoted.

EVOLUTION OF MODELS TO ENSURE LANGUAGE ACCESS

Each of the health centers came into existence and flourished in an environment where there were few, if any, models or standards for providing language and cultural access. Each health center has charted new ground and "evolved" with its own set of unique characteristics in response to the health needs of the local community.

Although practices and policies on language access and interpretation in the health centers vary considerably, all of the centers share a basic commitment to health care access for communities who face financial, linguistic, and cultural barriers. All centers have fundamental elements which can be described as part of the AAPCHO center model of ensuring language access. (see Fig. 14)

The Language Access Project authors have proposed general principles and specific standards and guidelines for providing linguistically and culturally competent primary health care to APIs. This section is a critical first attempt to identify those characteristics of health care that are key to providing appropriate care for API populations. The suggestions herein should be considered on the macro-level by health care officials and policymakers involved in reshaping our nation's health care delivery system, and on the micro-level by those organizations or agencies that are striving to make their services more linguistically accessible and culturally competent. Although based on the experience of API communities, many of these recommendations may also be applicable to other communities facing linguistic and cultural barriers to care.

PRINCIPLES

Appropriate care for APIs who are medically underserved is based on a few underlying principles. The principles below guide the work of the participating health centers. As health care policymakers consider health care reform, it is critical that these major principles be preserved.

- ✧ No individual should be denied access to health care because of language barriers.
- ✧ Health care organizations must provide care that is compatible with the cultural backgrounds of the patients served.
- ✧ Health care providers should provide equal and nondiscriminatory treatment of individuals and of all language/cultural groups.
- ✧ Providers throughout the entire spectrum of service delivery should reflect the cultures of the communities being served.
- ✧ Health care should be responsive to the health problems and needs of the community served.

In following these basic principles, health care organizations should strive to develop cultural competence. A culturally competent system of primary health care acknowledges and incorporates — at all levels — the importance of valuing diversity and culture, the expansion of cul-

tural knowledge, and the adaptation of services to meet culturally-unique needs. Cultural competence cannot be limited to any one aspect of a system, but must be system-wide and incorporated into policy, governance, service delivery, and consumer involvement.†

MINIMUM STANDARDS

Language Access

✧ Organizations that serve limited-English-speaking APIs must have systems for providing bilingual/multilingual staff *at key points of patient contact*. In other words, language services should be sufficient to ensure that the patients' initial access to services is not blocked or interrupted, that appropriate communications throughout the clinical visit are secured, and that follow-up and continuity of care are facilitated.

✧ Language access must extend beyond clinical services to include all services provided, such as health education programs and awareness campaigns and social and human services.

✧ Written materials and signs should be available for the major language/cultural groups using the facility. Written materials should, at minimum, include registration forms, informed consent forms, and treatment instructions. Signs should include locations of offices, departments, and rest rooms; consumer rights; and health center fees and policies. When appropriate, visual symbols (such as rest room signs and no smoking signs) can be used in lieu of writing.

✧ Health organizations should inform patients of the right to receive services in their language. For literate patients, this can be through written signs or information. Otherwise, verbally informing patients is appropriate.

† This definition was adapted from Cross, T.L., Barzron, B.J., Dennis, K.W., and Isaacs, M. *Towards a Culturally Competent System of Care - a Monograph On Effective Services for Children Who Are Severely Emotionally Disturbed*, CASSP Technical Assistance Center, Washington, D.C., 1989, p. V. The definition was revised by AAPCHO to apply to a primary care setting..

Cultural Competence

The governance structure of the health care organization should reflect the community served, have strong consumer involvement and strive toward providing culturally competent services.

Provider Skills

Individuals who provide services to limited-English-speaking APIs (multilingual/multicultural staff, interpreters, providers who work with interpreters) should have, in addition to the applicable language skills, appropriate training in health, cultural interpretation, provider-interpreter-patient roles and interactions, and patient rights (including confidentiality).

GUIDELINES

Language Access

1. Needs Assessment and Planning

Health care organizations should conduct ongoing needs assessments to identify the language needs of the community served. These language needs can be identified through census data, school district data, patient data, community surveys, and anecdotal data from community organizations and members. The needs identified should be addressed through planning and service delivery.

2. Methods for Ensuring Language Access

Different methods exist for ensuring effective language access. Health care organizations should strive toward the most effective methods of ensuring language access.

In deciding which of the methods (**described on page 13**) to use, several factors should be considered.

The anticipated demand for services for each language/cultural group. Method 1 (use of bilingual/multilingual staff without the use of an

interpreter) and Method 2 (interpretation by staff whose primary role is interpretation) are most appropriate in settings with a significant demand for services. In Method 1, the demand must be substantial enough to warrant having individuals at key points of patient contact with skills relevant to a particular language/cultural group. In Method 2, the demand must be substantial enough to warrant hiring a staff member who dedicates all of their time to interpretation. Method 3 (interpretation by staff for whom interpretation is a major but not exclusive job function) may be appropriate for settings in which there is a regular need for interpretation, but it is not constant. Method 4 (interpretation by staff who have other primary roles), Method 5 (use of outside interpreters) and sometimes Method 6 (telephone interpretation) may be appropriate in settings where there is a need for occasional interpretation in any particular language. As mentioned previously, health centers are encouraged to use the most effective interpretation methods (e.g. Methods 1 and 2), whenever possible, that will result in the most accurate, adequate, accessible and cost-effective interpretation.

To provide regular services for any one language/cultural group, an organization should have at least two individuals on staff with the applicable language and cultural skills. This allows for coverage if one individual is on leave or otherwise unavailable.

The number of language groups to be served. The use of bilingual/multilingual staff has several advantages. It can enable a small organization to meet the needs of several language/cultural groups without hiring multiple staff members for each individual language. It also can enable an individual in a particular job function to serve several language groups without using an interpreter. Further, if there is a small demand for services in one language, it may be impractical to hire staff members with capabilities in only that language. For multilingual staff, special care should be taken to test for fluency in all languages that they speak, not just in their primary API language.

Timing of interpretation needs. If interpretation services are needed for drop-ins or handling telephone calls, having an on-site interpreter is very

important. Using outside interpreters is easiest when scheduled in advance. Otherwise, there may be scheduling conflicts or a long waiting period for the interpreter to arrive. Using telephone interpretation for unscheduled interpretation needs may be the best solution if there is no interpreter on-site. However, telephone interpretation is not recommended when complex medical information is being communicated.

Various factors may impact a health center's ability to ensure language accessible methods. These factors include 1) the ability to recruit, train and retain individuals in different roles with language/cultural skills; 2) the ability to form partnerships with other providers; and 3) accountability and liability issues.

Due to the limited pool of qualified individuals, health organizations should be prepared to make an investment in recruiting bilingual/bicultural and multilingual/multicultural staff. Such recruiting efforts may include extensive networking, advertising, or cultivating relationships with future candidates who are not immediately available. Health organizations also should be prepared to sustain vacancies for a period of time while seeking to fill positions and/or to recruit individuals with most of the desired skills, but who require some additional training.

Health care organizations should provide training opportunities for staff (either on-the-job training, in-service training programs, or outside training programs) to enable staff members to develop required skills. Such training should be ongoing to reinforce skills development and provide opportunities for new staff. During the initial training period, health care organizations should recognize that new staff members may be unable to assume the entire scope of responsibilities and make necessary adjustments.

It will be important for health care organizations to develop partnerships with other providers that have similar language/cultural needs. These partnerships can be mutually beneficial in developing a cadre of trained and tested bilingual/multilingual personnel. However, the partnerships may be more difficult to establish when using methods that involve only occasional interpretation by staff or the use of outside interpreters.

Regardless of which method of interpretation is used, some level of oversight and accountability must be maintained to ensure quality of interpretation and patient confidentiality. If staff interpreters, volunteers, or consultants are used, oversight can occur directly between that individual and the organization. If an outside organization such as a language bank is used, it would be important to establish a formal mechanism with that organization. When outside organizations are used, liability may be a concern when problems of miscommunication arise.

POLICY RECOMMENDATIONS

The recommendations presented in this section are designed to promote the development of culturally and linguistically accessible health care for API populations. In redefining and reshaping the nation's health care system, it is crucial that the community-based models that enhance access to health care be preserved and promoted. The health center experience also points to a need for strengthening system-wide responsibility for linguistically and culturally appropriate care among individual health organizations and through system-wide approaches such as language banks.

1) Solidify the Infrastructure Serving APIs to Overcome Access Barriers

Despite the growing need for multilingual/multicultural services, efforts to develop the required infrastructure to meet those needs have been limited. In 1990, Congress reaffirmed the importance of language access through the reauthorization of the community health center program. An amendment in the reauthorization states that "if a substantial number of the individuals in the population served by a center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals is necessary."

Although this explicit requirement for language access was an important step in health center policy, it was not accompanied by an appropriation of funds to enable health centers to comply. Health centers are not compensated for

the added responsibility, staff resources, training, and cost required to provide linguistically and culturally accessible services. Some limited mechanisms to support language access services exist, but they are alarmingly insufficient considering the scope of activity required to provide linguistically accessible services. The need for such resources extends to other providers of linguistically and culturally accessible services.

As documented in this report, community health centers serving API communities should consider a tremendous responsibility for ensuring system-wide access to health care for their patients and other community members. They are hampered in their efforts to serve their community by a lack of commitment to language and cultural access among other providers (e.g., hospitals, managed care organizations) as well as a lack of system-wide resources to support their efforts. The Language Access Project demonstrated that when system-wide supports (such as language banks and interpreter training programs) exist, it can reduce the burden of the health centers serving APIs.

Specific recommendations to strengthen the infrastructure include:

☞ 1.1 Seek funding for system-wide approaches for meeting language needs, such as language banks and programs for training and recruitment of staff in areas with multiple ethnic/language groups.

☞ 1.2 Encourage linkages between health care providers to promote collaborative efforts and responsibility for providing linguistically and culturally appropriate services.

☞ 1.3 Acknowledge and appropriately compensate health care providers who perform interpretation and other language-related services within the health care delivery system. Medicaid and Medicare reimbursement mechanisms should cover costs of providing services to the beneficiaries of these programs. Additional funding streams should be created to cover costs for uninsured patients.

☞ 1.4 Consider the costs related to language and cultural access in the context of the current managed care environment. Such costs should be considered in budgeting, reimbursement, and financing mechanisms.

2) Strengthen and Enforce Legal and Administrative Mandates Protecting Civil Rights

As documented in this report, many health organizations do not make their services linguistically and culturally accessible. This reality affects health center patients when seeking the services of other providers. Without the benefit of a community health center to assist them, many APIs face even greater barriers to health care. One factor in this lack of system-wide responsibility is the dearth of explicit legal mandates, standards, and enforcement mechanisms. According to Title VI of the Civil Rights Act of 1964, any program or activity that receives any form of federal financial assistance must not exclude or discriminate against any individual on the basis of race, color, or national origin.¹ As interpreted by the U.S. Department of Justice affirmed through legal precedent, Title VI prohibits discrimination based on language.²

The Civil Rights Act recently was amended to provide more explicit standards related to employment discrimination. However, there has never been explicit language in the law relating to discrimination on the basis of language in service delivery. There also has been a lack of administrative mandates and mechanisms to inform organizations of this legal obligation and ensure its enforcement. As a result, despite the existence of this broad legal mandate for more than 30 years, federally funded programs repeatedly have been found to discriminate on the basis of language.

☞ 2.1 Encourage and support legislation that will explicitly protect the civil rights of individuals who face language and cultural barriers to care.

☞ 2.2 Develop and adopt in all agencies of the U.S. Department of Health and Human Services (DHHS) measurable standards requiring recipi-

ents of funds to provide linguistically accessible health care and develop mechanisms for monitoring compliance with these standards.

☛ 2.3 Support expansion of activities of the Office for Civil Rights, DHHS, to enforce the Civil Rights Act. These efforts should include working with various DHHS agencies to monitor compliance by recipients of federal funds and to expand dissemination of civil rights information to providers and patients.

☛ 2.4 Increase efforts to inform patients of their rights to receive culturally and linguistically appropriate health care within limited English-speaking communities. Furthermore, mechanisms should be strengthened to respond to patient complaints and to enact corrective action when patient rights are violated.

3) Identify and Address the Needs of Underserved APIs

The growth of the API population has resulted in increased demand for services within API communities. As documented in this report, the API communities served by the participating health centers are spread over wide geographic boundaries and are clustered in dispersed areas. For this reason, current approaches to identifying primary care needs based on geographic units are often inadequate. This is aggravated by a lack of data, both on API health status and on the availability of providers to serve API communities.

The potential exists for this problem to be further heightened under health care reform. Under health care reform, data and methodology for identifying needs will play a major role in the restructuring of health care delivery systems and the expansion of services to underserved communities.

☛ 3.1 Support additional efforts to identify unmet needs among APIs in the service areas of existing health centers and other geographic areas. Methodology for identifying and addressing need should be flexible and acknowledge that underserved communities are often dispersed over large geographic areas.

☛ 3.2 Increase federal, state, and local governments efforts to identify the needs of medically underserved API communities through improving data systems to identify and monitor needs combined with community-based surveys and needs assessments.

References:

¹ *United States Department of Health, Education and Welfare. Nondiscrimination in Federally-Assisted Programs U.S. DHEW Regulation Under Title VI of the Civil Rights Act of 1964, as amended through July 5, 1973. 1973.*

² *Nisbikawa, A. Barriers to Health Care: Improving Services to Non-English Speaking Patients in Sonoma County, November 1989. Unpublished document prepared for Community Hospital.*

Appendix A

1990 U.S. Census Categories for APIs

ASIAN

Asian Indian
 Bangladeshi
 Bhutanese
 Borneo
 Cambodian
 Celebesian
 Ceram
 Chinese
 Filipino
 Hmong
 Indochinese
 Indonesian
 Iwo-Jiman
 Japanese
 Javanese
 Korean
 Laotian
 Malayan
 Maldivian
 Nepali
 Pakistani
 Sikkim
 Singaporean
 Sri Lankan
 Sumatran
 Thai
 Vietnamese
 Asian, not specified
 Okinawan
 Other Asian

PACIFIC ISLANDER

Carolinian
 Fijian
 Guamanian
 Hawaiian
 Kosraean
 Melanesian
 Micronesian
 Northern Mariana Islander
 Palauan
 Papua New Guinean
 Polynesian
 Ponapean (Pohnpeian)
 Samoan
 Solomon Islander
 Tahitian
 Tarawa Islander
 Tongan
 Trukese (Chuukese)
 Yapese
 Pacific Islander, not specified
 Other Pacific Islander

Appendix B

Description of AAPCHO Centers

Asian Health Service (AHS) Oakland, CA

Founded in 1973, AHS began offering direct medical services to APIs in Alameda County in 1975. Its central mission is "to serve and advocate for the immigrant and refugee Asian community regarding its health rights and to assure access to health care services regardless of income, insurance status, language, or culture."

As a provider of multi-cultural, multi-lingual services, AHS has always been at the forefront of designing and implementing innovative programs and services to meet the specific needs of its population. In addition to primary care, AHS offers:

- ☞ **Language and Cultural Cooperative-** development of a shared medical interpretation resources model
- ☞ **Television Health Promotion Series-** production of a series of TV spots with fact sheets, for local ethnic language channel on health topics that affect the Asian community
- ☞ **Comprehensive HIV/AIDS Program-** education, risk reduction, prevention and social case management, HIV testing and counseling, and primary care
- ☞ **Labor Coach Services-** pairing of patient with trained bilingual labor coach for labor and delivery; part of a Comprehensive Perinatal Program
- ☞ **Multi-lingual Health Education Materials-** collection of AHS health education materials in different patients' languages; includes instructional videotapes on smoking prevention and cessation and AIDS education
- ☞ **Survey Research-** seminal behavioral risk factor survey (BRFS) of Oakland Chinese, Alameda County Koreans, and Alameda County Laotian and Mien
- ☞ **Data Development-** participation in AAPCHO's Uniform Data Base Project, as well as management information system (MIS) which tracks visits by diagnosis and health status

Asian Pacific Health Care Venture (APHCV) Los Angeles, CA

Founded in 1986, APHCV serves as a non-profit coalition based organization serving the Asian Pacific communities in Los Angeles County. Its overall mission is to plan, provide, promote, and coordinate accessible, affordable, culturally competent, and effective health services to the underserved, Asian Pacific communities.

Working to address the needs of APIs in LA County, APHCV focuses on both research and data development as well as model development. Efforts to generate more data on the health and welfare of APIs include:

- ☞ **Primary Health Care Uniform Database Development-** successful computerization of each of their previous member agencies' patient registration forms for over 5,600 patients
 - ☞ **AAPCHO Tuberculosis Control and Prevention Project-** establishment of cultural barriers to access/treatment of tuberculosis; strengthening and formalizing referrals between API service providers and the County health system
 - ☞ **Health Education and Risk Reduction Project (HERR)-** generation of baseline data on the health of APIs in LA County, and its distribution to congressional officials
 - ☞ **Antihypertensive Lipid Lowering treatment to prevent Health Attack Trial (ALLHAT) -** participation in clinical trials to determine effectiveness of newer blood pressure, patients receive free medication
- This research lays the framework for the development of culturally appropriate models of health education and primary health care service delivery. Examples of these models include:
- ☞ **Youth Asian Pacific United Against Tobacco (YAPUT)-** addresses youth access to tobacco in API communities, targets leadership development and merchant education Hepatitis B Prevention Project- comprehensive hepatitis B services, includes joint case management, referrals, free vaccines, education, and trainings
 - ☞ **Perinatal Peer Education Project-** train-the-trainer model of providing perinatal health care to API women, recruits women in different ethnic communities as peer educators

Chinatown Health Clinic (CHC) New York City

Established in 1971, CHC provides primary care emphasizing preventive medicine, health education, and community involvement. Its mission is to: provide personalized, family-oriented, culturally relevant, quality ambulatory health care to the Chinese community; educate community residents about preventive medicine, health promotion, health maintenance, available services, and patients' rights; advocate for improved patient accessibility to health care institutions, making these institutions responsive to patient needs; and recruit and train future health care workers, developing their understanding of community needs and problems, and encouraging an interest in community involvement upon completion of their training

As the only health care choice of many of the Chinese immigrants in the New York City metropolitan area, CHC offers a full range of health care services in addition to primary care which includes:

- ☞ **Consultations** in allergy, dermatology, and pediatric cardiology
- ☞ **Three-operator Dental Suite**
- ☞ **Eye Care Center-** includes a diabetes and glaucoma screening program
- ☞ **Sigmoidoscopy Room**
- ☞ **Cancer Prevention Programs-** includes PAP smears and smoking prevention activities
- ☞ **Health Education-** multi-media, community outreach which includes topics on tuberculosis, hepatitis B, women's health, hypertension, nutrition, child safety, and AIDS

International District Community Health Center (IDCHC) Seattle, WA

Established in 1975, IDCHC targets the low-income, limited- or non-English speaking API population in Seattle and King County. Its mission is to provide culturally sensitive, accessible, affordable and comprehensive primary care services to APIs and other members in the community. IDCHC's health care services focus on education, prevention, and early intervention.

IDCHC staff speak 14 different Asian languages and dialects, utilizing bilingual Family Health Workers (FHW). In addition to comprehensive primary medical care and access to extended specialty care, the center provides:

- ☞ **Mental Health Counseling**
- ☞ **WIC Food Voucher Program**
- ☞ **Foot Care**
- ☞ **Family Planning Services**
- ☞ **Contracted Dental Referral Care**
- ☞ **On-site Laboratory and Pharmacy**

IDCHC also participates in collaborative health care ventures to provide improved health care, such efforts include participation in:

- ☞ **Community Health Council of Seattle/King County**
- ☞ **Central Seattle Community Health Centers**
- ☞ **Community Health Plan of Washington-** managed care plan that coordinates statewide networking using an integrated MIS, joint purchasing of shared services, and coordinated planning for clinical management and quality assurance in a managed care environment
- ☞ **Seattle/Chinatown International District Preservation Development Authority's Village Square Project-** facilitation of interagency collaboration and promotion of innovative models providing services to the API communities

Kokua Kalihi Valley Health Center (KKVHC) Honolulu, HI

Established in 1972, KKVHC is the only health care agency in Kalihi Valley dedicated to providing health care and social services to the low-income, mostly API community. Its mission is to be an agent for the promotion of healing and reconciliation in the Kalihi Valley Community.

In addition to comprehensive medical and dental services, KKVHC offers:

- ☞ **Family Planning Program**
- ☞ **WIC/Nutrition**
- ☞ **Healthy Babies Health Moms-** comprehensive perinatal program
- ☞ **Social Services-** with special focus on youth
- ☞ **Outreach Services and Eligibility work/ACCESS to Health Program-** assistance in applying for welfare and/or health insurance programs

KKVHC has evolved into an important site for health professional training in Hawaii and offers a wide range of quality programs. Additional projects and activities include:

- ☞ **Hepatitis B Outreach and Immunization Project**
- ☞ **Hepatitis B Outreach and Research Project-** immunization for public housing children, development of education and immunization of low-income API children and their families
- ☞ **Access to Health-** addresses primary health care needs of public housing residents through outreach, satellite health centers at housing projects, and health education
- ☞ **HIV/STD Education-** educates adolescents in public housing
- ☞ **Professional Education-** training for students in health care related disciplines
- ☞ **The Kalihi-Palama Health and Human Services Development Corporation-** conglomeration of 16 public and private agencies dedicated to the health and welfare of the residents of the Kalihi-Palama area

North East Medical Services (NEMS) San Francisco, CA

Established in 1968, North East Medical Services is a private, non-profit community health center. Its overall mission is "to provide comprehensive, outpatient health care services to the medically underserved population of San Francisco."

NEMS physicians provide 24-hour coverage and in-patient care. In addition to primary and specialty medical services, NEMS offers:

- ☞ **Dental**
- ☞ **Optometry**
- ☞ **Laboratory and X-ray**
- ☞ **Pharmacy**

NEMS has experience in conducting and participating in research, evaluations and educational campaigns. Its program experience includes:

- ☞ **Health Education Department-** culturally appropriate programs range from one-to-one counseling, group classes, health fairs, media programs (TV, live-radio, newspaper columns), audio-visual and literature publications
- ☞ **Computer Tracking System-** tracks patient diagnosis and diseases to maintain quality of care, internal management, and to support research activities
- ☞ **Professional Development-** site for professional students in health care fields ranging from medical, dentistry, optometry, public health, nursing, pharmacy, and health education; students in elementary and secondary schools also work with NEMS staff

South Cove Community Health Center (SCCHC) Boston, MA

Founded in 1972, SCCHC's mission is to provide accessible and affordable health care to the Asian community in the metropolitan Boston area. Priority is given to low income, first generation Asian immigrants and refugees.

In addition to basic primary and preventive care in health, mental health, and dental, SCCHC offers specific services which include:

- ☞ **School Health Services**
- ☞ **Crisis Intervention Services to Southeast Asian Children and Families**
- ☞ **Case Management Services for Homebound Elderly**
- ☞ **Genetic Screening Services for Families with Thalassemia**
- ☞ **Health Insurance Planning Center-** helps uninsured families purchase health insurance
- ☞ **Outreach Health Education Services**

Currently, SCCHC houses over 20 programs devoted to those health risks prevalent within the API population. Future plans include expansion into a Regional Primary Care Center and construction of a Family Life Center within Boston's Chinatown to promote preventive and family-oriented community health programs. Its programs include:

- ☞ **Cancer Awareness Project-** improve community awareness of cancer risks; includes a community coalition project to target smoking among Asian males
- ☞ **Men of Color-** initiative providing free physical exams for uninsured Asian men
- ☞ **Clinical Data Tracking System-** collect clinic data through billing system
- ☞ **Junior Health Careers Opportunity Project-** promote interest in health careers among PI teenagers with Boston University

Appendix C

**Time Study of Cost Comparison of Same-Language
Encounters and Interpreter-Dependent Encounters**

HYPOTHESIS

Encounters involving the use of interpreters (interpreter-dependent encounters) would be more expensive than encounters conducted in the patient's language without the use of interpreters (same-language encounters).[†]

Methods

Costs associated with different methods of ensuring language access were compared. Data from the providers at the health center sites were collected and analyzed to identify differences in time spent and costs incurred between same-language encounters and interpreter-dependent encounters.

Sampling frame. This study was conducted in six AAPCHO health center sites. The original design of the cost study called for the examination of the percentage time spent with patients on language access functions in three staff categories: clinical providers, direct contact, and indirect contact.^{††} However, the goals of the cost study were reformulated after a working meeting in April 1993, and a decision was made to concentrate on the data from clinical providers.

Health center clinicians completed forms which identified the time spent for every patient encounter over a one-week period. Separate columns were provided for same-language encounters and interpreter-dependent encounters. Completed forms were sent to the project liaisons for review and then to AAPCHO for data entry.

Data from the six health center sites were aggregated in the analysis. Some data demonstrated irregular patterns of time-lengths and were considered outliers. Due to these irregularities, outlier data were not used in the analyses.

Analyses included a comparison of same-language encounters with interpreter-dependent encounters by length and cost of encounters. Salaries and fringe benefits were included in the

calculation of the cost of encounters according to length of time. Data were also analyzed by provider type which influences encounter length and costs. An analysis of time interval by provider type was conducted to determine whether cost difference was higher for longer visits. T-tests were performed on the comparisons to test the reliability of results.

Limitations

Study Design. The initial study design was limited because it did not isolate language access-related functions from other functions within the health centers. These functions and their associated costs are extremely difficult to isolate, because language access is integral to all health center activities. The design of the cost study was changed after examining preliminary results, which indicated that analyzing data from clinical, direct, and indirect staff was not feasible within the time frame of the project. Therefore, priority was given to the analysis of data from the clinical providers.

Availability of Data. In addition, there was a lack of data because health center sites did not routinely track costs related to language access in recruitment and training. There also was a lack of data for comparison purposes from health center sites serving large English-speaking populations. Future studies should seek alternative methods of identifying and quantifying costs related to language access.

Small sample size. Since the sample was fairly small for most of the specialty areas, it was difficult to achieve a statistically significant result except in a few instances.

Further analyses needed. This study represents only a preliminary look at costs associated with language access. Further studies are needed to isolate separate variable costs associated with language access in API community-based clinics and to compare results with, for example, health centers that do not require special clinical interpretation.

[†] *Interpreter-dependent encounters* are those in which an interpreter must be used to facilitate communication between the patient and provider. *Same-language encounters* refer to encounters in which the provider speaks the same language as the patient and is able to communicate directly with the patient without the use of an interpreter.

^{††} *Direct contact* is defined as the time spent by those direct services staff, other than clinical providers, who regularly spend more than 10 percent of their time with patients. *Indirect contact* is the time spent by non-direct services staff with patients.

Findings

Same-language encounters comprised 81.4 percent of all health center encounters and exceeded interpreter-dependent encounters in all centers except for Seattle's IDCHC. **Fig. 15** gives a breakdown of encounter visits by length of time and costs in the clinics.

Since length and cost of encounter is influenced by provider type, data were analyzed by provider type. Internists (30.5 percent), dentists (14.3 percent), and pediatricians (13.5 percent) made up the majority of the provider encounters

Provider Type

All provider types cost more for interpreter-dependent encounters than for same-language encounters (see **Fig. 16**). However, only the results for internists and physician's assistants were statistically significant (p value $< .05$). In addition, with all provider types except for family practitioner and dentist, the length of the encounter took longer in interpreter-dependent encounters than in same-language encounters. The internist data provided statistically significant results. Although only two provider specialties gave statistically significant results, the trend can be shown that for most provider types, interpreter-dependent encounters in each specialty cost more and took longer than same-language encounters in the same specialty. This suggests that the need for an interpreter lengthens the amount of time needed for an encounter and increases costs because two staffpersons' salaries are involved.

Provider Type by Time Interval Breakdowns

An analysis was done to measure the difference in cost between interpreter-dependent and same-language encounters by provider type and by time interval. The most striking results were found among the internists, physician assistants, and obstetricians/gynecologists. With respect to the length of encounters, internists in interpreter-dependent encounters took 2.39 minutes longer on average than a same-language encounter at the 11- to 20-minute period, but less time in a 1- 10-minute period. For

internists, an 11- to 20-minute interpreter-dependent encounter cost \$6.17 more than a same-language encounter (see **Fig 17**); the difference increased to \$16.47 for a 21- to 30-minute visit and \$15.04 for a 41-minute (or longer) visit. However, for internists, a 1-10 minute interpreter-dependent encounter cost less than a same-language encounter for the same interval.

For obstetricians/gynecologists, an interpreter-dependent encounter cost \$6.57 more than a same-language encounter for the 1- to 10-minute interval but \$5.81 less for a 11-20 minute visit. For physician assistants, an interpreter-dependent encounter cost \$4.27 more than a same-language encounter in the 11- to 20-minute interval and \$7.71 more in a 21- to 30-minute visit.

Discussion

It seems logical that a longer interval patient encounter would cost more than a shorter encounter.

Figure 15

Percentage of Same Language Encounters for Cost Comparison by Health Centers

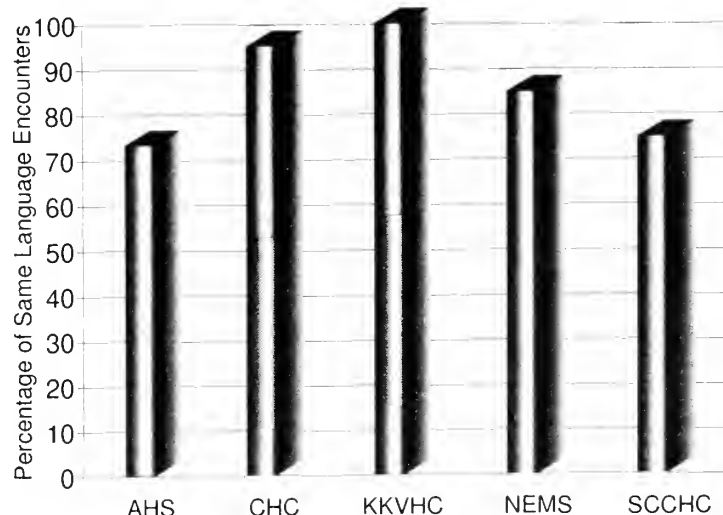
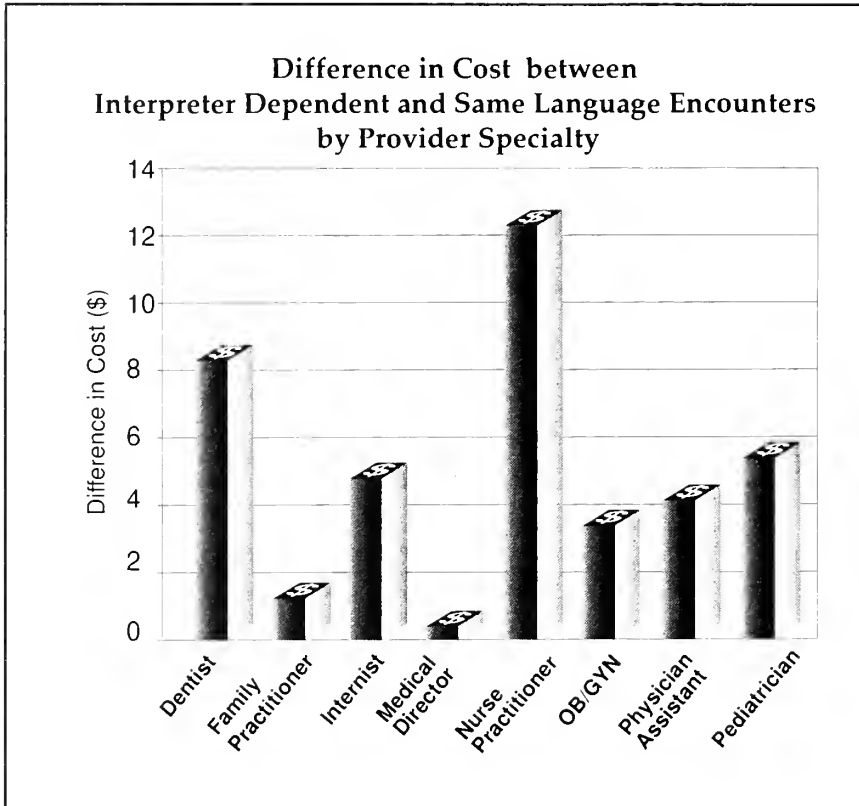


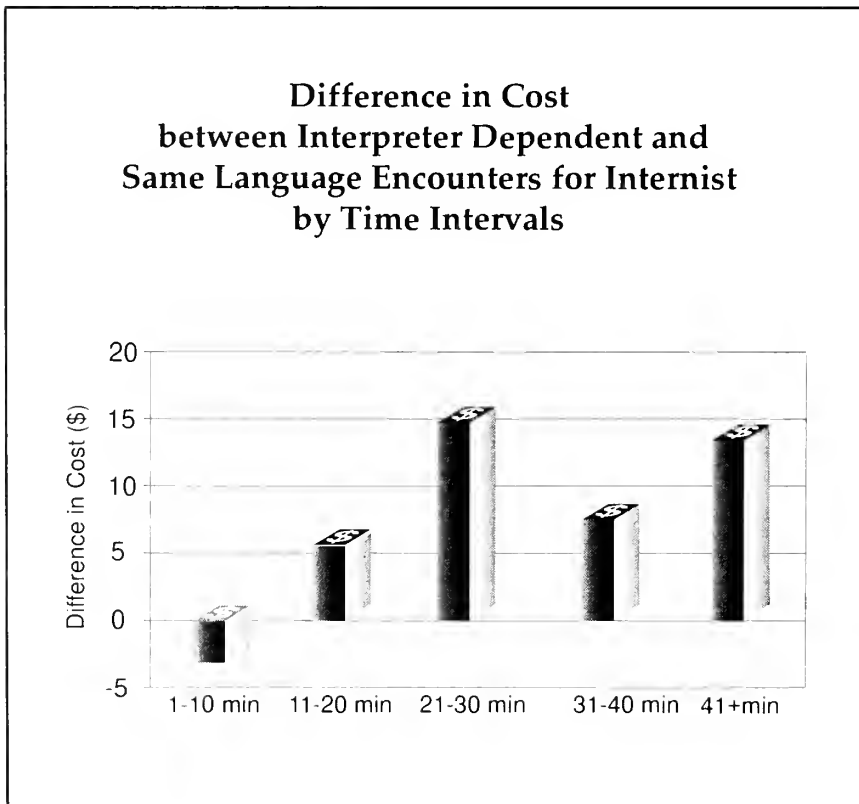
Figure 16



Therefore, since internists using interpreters spent more time with the patients during 11-20 minute visits than same-language encounters, it would make sense that it costs more for those visits. However, it is not clear why the average time spent by interpreter-dependent specialists would vary so much by time interval breakdown. Additional studies are needed to explore these complexities further.

Due partly to the small sample size for certain provider specialties, many of the results were not statistically significant except for internists, obstetricians/gynecologists and physician assistants. Contrarily, perhaps the data for internists was statistically significant because they had the highest number of encounters or they had the longest length of visit compared to other specialists. Also, for some provider types, there may be less of a need for language interpretation services than for others. For example, dentists may have less verbal interaction with patients than other provider types. For some provider specialties, this study can only provide trends in describing the relationship between cost differences between interpreter-dependent and same-language encounters. This underlies the importance of funding additional studies to examine the complex costs issues and variables related to interpretation services in a diverse multilingual API clinical setting.

Figure 17





Association of Asian Pacific Community Health Organizations
1440 Broadway, Ste. 510
Oakland, CA 94612

Telephone: (510) 272-9536

Fax: (510) 272-0817

E-mail: info@aapcho.org